STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 15-020685 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] Appellant's mother, appeared and testified on Appellant's behalf.

[redacted] Assistant Corporation Counsel, Macomb County Community Mental Health Authority, represented the Department (CMH or Department). [redacted] appeared as a witness for the CMH.

ISSUE

Did the Department properly terminate Appellant's CMH services because it determined that Appellant was not eligible for CMH services as a person with a Developmental Disability (DD)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted]-year-old Medicaid beneficiary, born [redacted], who is diagnosed with Autism/Asperger's/Rett's Disorder. (Exhibit A, pp 18, 34; Testimony)

2. Appellant resides with his mother and two siblings. (Exhibit A, p 11; Testimony)

3. Appellant is in the [redacted] grade at [redacted] and receives special education services for his autism spectrum disorder. Appellant is in one special education class and receives appropriate assistance in his other classes. (Exhibit A, p 18; Testimony)

4. Appellant's full scale IQ is 107. Appellant is intelligent, makes appropriate eye contact, and his ability to do math calculations is high. Appellant sometimes struggles with socializing and dealing with his emotions, but has made progress in these areas during the past year. Appellant is sometimes verbally aggressive, but otherwise does not exhibit challenging behaviors. (Exhibit A, p 18; Testimony)

5. Appellant needs assistance with some tasks of self-direction. Appellant needs to be prompted to bathe every other day and he tends to isolate himself in his room and often declines social outings with the family. Appellant struggles with tying his own shoes. (Exhibit A, pp 18-19; Testimony)

6. Appellant is otherwise independent with his Activities of Daily Living (ADL's). Appellant is able to feed himself, dress himself, toilet himself, bathe himself and brush his own teeth. Appellant is able to make basic food choices, dress appropriately for the weather, and he knows how to count money and can calculate change in his head, including the sales tax. (Exhibit A, pp 18-19; Testimony)

7. Appellant is able to express his basic needs and he can answer more than simple questions. Appellant is able to relate his personal experiences and he can follow 1-2 step directions. Appellant can tell time, he knows his mother's cellphone number, and he has his own cellphone and knows how to use it. (Exhibit A, pp 18-19; Testimony)

8. Appellant is able to complete household chores and does so after prompting. Appellant is able to prepare simple meals. Appellant is able to make simple purchases, but tries to avoid doing so because of the social interaction required. Appellant is able to call 911 and he has an understanding of household dangers. Appellant is able to ride his bike safely through the mobile home park where he lives, but otherwise does not navigate the community alone. Appellant understands traffic lights and knows how to cross the street safely. (Exhibit A, pp 18-19; Testimony)

9. On [redacted], CMH conducted an Access Screening with Appellant. Following the screening, CMH concluded that Appellant did not meet the criteria for services as someone with a DD because he did not have a substantial limitation in three or more areas of major life activities. (Exhibit A, pp 11-34; Testimony)

10. On [redacted] CMH sent Appellant a notice indicating that his services would be terminated effective [redacted] (Exhibit A, pp 5-7; Testimony)

11. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted] (Exhibit 1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR).

It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> 42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

The applicable sections of the Medicaid Provider Manual (MPM) provide:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual
Mental Health & Substance Abuse Chapter
July 1, 2015, pp 12-14

The Medicaid Provider Manual also lays out the responsibilities of Medicaid Health Plans (MHP's) and CMH's:

> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
• The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. • The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional	• The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). • The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual

disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. • The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

Medicaid Provider Manual
Mental Health & Substance Abuse Chapter
July 1, 2015, p 3

The CMH Representative indicated that the Michigan Mental Health Code definition of developmental disability was utilized by CMH to determine Appellant was not eligible for CMH services. That definition provides, in pertinent part:

> (21) “Developmental disability" means either of the following:
>
> (a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:
>
> (i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
> (ii) Is manifested before the individual is 22 years old.
> (iii) Is likely to continue indefinitely.

> (iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
>
> (A) Self-care.
> (B) Receptive and expressive language.
> (C) Learning.
> (D) Mobility.
> (E) Self-direction.
> (F) Capacity for independent living.
> (G) Economic self-sufficiency.
>
> (v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
>
> *MCL 30.1100a*

CMH's Access Center Manager testified that the Access Center makes eligibility and level of care determinations for persons who request services and for the continuation of services. CMH's Access Center Manager testified that Appellant is [redacted] years old and is diagnosed with Asperger's syndrome. CMH's Access Center Manager indicated that Appellant attends regular classes at school with supports appropriate to his diagnosis. CMH's Access Center Manager reviewed the definition of Developmental Disability from the mental health code and concluded that Appellant was not eligible for services as a person with a Developmental Disability (DD) because he did not have a substantial functional limitation in three or more areas of major life activities. CMH's Access Center Manager indicated that the only area of major life activity where Appellant had a substantial limitation was in the area of self-direction.

Appellant's mother testified that Appellant is a very respectful young man and attends one special education class and receives supports in his other classes. Appellant's mother indicated that Appellant requires a lot of prompting to brush his teeth, bathe, use deodorant, etc. Appellant's mother testified that it can be difficult to differentiate Appellant from a normal teenager, but that he literally will not talk to anyone unless forced to do so. Appellant's mother indicated that her other two children are very verbal and outgoing and take care of their personal needs with much less prompting required. Appellant's mother testified that Appellant has been receiving services through CMH for the past three years and she has seen immense improvements during that time period. Appellant's mother indicated that she has also seen Appellant revert a little to his old ways since the services have ended.

Based on the evidence presented, Appellant did not prove, by a preponderance of the evidence, that the denial of requested CMH services was improper. The evidence shows that Appellant's full scale IQ is 107, he is intelligent, makes appropriate eye contact, and his ability to do math calculations is high. Appellant is independent with his Activities of Daily Living (ADL's) as he is able to feed himself, dress himself, toilet himself, bathe himself and brush his own teeth. Appellant is able to make basic food choices, dress appropriately for the weather, and he knows how to count money and can calculate change in his head, including the sales tax. Appellant is able to express his basic needs and he can answer more than simple questions. Appellant is able to relate his personal experiences and he can follow 1-2 step directions. Appellant can tell time, he knows his mother's cellphone number, and he has his own cellphone and knows how to use it. And while Appellant needs significant assistance with self-direction, that is the only substantial limitation Appellant has in a major life activity. Appellant does not have a substantial limitation in the areas of self-care, receptive or expressive language, learning, mobility, or capacity for independent living. Because of his age, Appellant's economic self-sufficiency is not an issue at this time.

As such, CMH was correct in determining that Appellant was not eligible for services as a person with a Developmental Disability (DD) because he did not have a substantial functional limitation in three or more areas of major life activities. Accordingly, the Department's denial of Appellant's request for continued CMH services must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that Appellant was not eligible for CMH services as a person with a Developmental Disability.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

RJM/cg

Date Mailed: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.