STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 15-010332 CMH

[redacted]

Appellant

_____/

AMENDED DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on his own behalf. [redacted]., Appellant's father, also testified as a witness for Appellant. [redacted] Corporation Counsel, represented the Respondent Community Mental Health of [redacted] (CMH). [redacted], Fair Hearing Officer, and [redacted], Program Coordinator, testified as witnesses for the CMH. [redacted], Customer Services Coordinator, was also present as an observer for Respondent.

On [redacted], the undersigned ALJ issued a Decision and Order concluding that the CMH properly terminated Appellant's services and affirming its decision to do so.

On [redacted], MAHS received a Request for Expedited Decision; a Stipulation between the parties; an [redacted] Circuit Court Order dated [redacted] a Psychosocial Assessment dated [redacted]; an Appearance by an attorney for Appellant; and a Proof of Service

In the Stipulation, the parties agreed to an order remanding the case back to MAHS in order to supplement the record with the [redacted] Psychosocial Assessment and to require the undersigned ALJ to issue a new or amended decision and order after consideration of the new evidence.

In the Circuit Court Order, issued by the [redacted] of [redacted] Circuit Court, [redacted] ordered that: (1) the case be remanded back to MAHS to supplement the record; (2) the undersigned ALJ issue a new or amended decision and order after consideration of the new evidence; the undersigned ALJ file the additional

evidence and the new or amended decision and order with [redacted] Circuit Court; and that the Circuit Court appeal be stayed until the above filing is made.

Upon review, the copy of the [redacted] Psychosocial Assessment submitted by Appellant was unreadable in several parts as the text at the bottom of its pages fadeed way and eventually disappeared. Accordingly, on [redacted], the undersigned ALJ issued an Order requiring Appellant must produce a new, complete, and readable copy of the [redacted] Psychosocial Assessment to MAHS by [redacted].

Appellant's representative submitted a new, legible copy of the [redacted] Psychosocial Assessment that same day and the assessment was entered into the record as Exhibit 2.

ISSUE

Did the CMH properly terminate Appellant's services?

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 f[redacted] year-old Medicaid beneficiary who has been diagnosed with Obsessive-Compulsive Disorder (OCD); Impulse-Control Disorder NOS; and mild mental retardation. (Exhibit 2, page 6; Exhibit J, pages 1, 5).

2. On [redacted], Appellant requested and was assessed for services through the CMH as a person with a developmental disability. (Exhibit J, pages 1-6).

3. However, that assessment concluded that Appellant did not meet the criteria for having a developmental disability. (Exhibit J, pages 1-6; Testimony of [redacted]).

4. Specifically, the assessment concluded in part:

> [Appellant] is functioning well in the areas of self care, learning, mobility, self direction, capacity for independent living and economic self sufficiency. He will at times have some difficulty with expressive communication, as he tends to hold back responses. His receptive communication is quite high.

> The various life activity areas were reviewed and discussed . . . It was explained that he did not meet the criteria for substantial impairment in any of the seven areas.
>
> *Exhibit J, page 6*

5. Appellant did not appeal or request and administrative hearing with respect to that determination. (Testimony of [redacted]).

6. On [redacted], Appellant did have a case opened with the CMH as a person with a serious mental illness. (Exhibit K, page 1).

7. Most recently, Appellant had been receiving the services of targeted case management; medications reviews, and non-emergency transportation through the CMH. (Exhibit D, pages 1-3).

8. The transportation was provided to-and-from Appellant's employment at [redacted]. (Exhibit 2, page 2; Testimony of Appellant's father; Testimony of [redacted].

9. The employment itself was not provided through the CMH. (Exhibit 2, page 2; Exhibit D, pages 1-3; Testimony of [redacted].

10. On [redacted], Appellant was assessed by [redacted], LLMSW, under the Level of Care Utilization System (LOCUS) and he scored as a [redacted] based on his minimal risk of harm; moderate impairment, positive engagement; mildly stressful environment; and supportive environment. (Exhibit B, page 1).

11. On [redacted], the LLMSW also completed a face-to-face meeting and annual Psychosocial Assessment with Appellant. (Exhibit 2, pages 1-6).

12. During that assessment, the LLMSW noted:

> [Appellant's current need for services is to maintain stability and prevent relapse. His behaviors have all but disappeared over the years due to prescribed psychotropic medication, close monitoring by providers and other natural supports. [Appellant] has not had problems with any of these behaviors since [redacted]. [Appellant] indicates "I get urges to steal other[s belongings, but don't act on it". 'I am now able to control my urges". Dad states "he has matured a lot over the last few years."

> [Appellant's] current need for services include medication reviews for symptom management and limited case management by team clinician for monitoring purposes. [Appellant] is satisfied with his mental health stability and level of functioning. [Appellant] is in the maintenance stage of his recovery. [Appellant's] current LOCUS score is [redacted] due to level of supports available to him and symptom stability.
>
> *Exhibit 2, page 1*

13. The LLMSW also noted in the assessment:

> [Appellant] has benefitted from [redacted] services, particularly medication management and case management. Parents worry sometimes that [Appellant] is doing too well and will get "kicked out" of CMH services again but were assured that current services appear to be what helps [Appellant] stay stable at this time. If he were to "retire" from working, he may then be stepped down in services to the point where he could be in a general AFC home without CMH support.
>
> *Exhibit 2, page 2*

14. The Psychosocial Assessment also contained a Developmental Disability Addendum in which it was stated that Appellant is an individual older than [redacted] years of age who has a severe and chronic condition that is attributable to a mental and/or physical impairment and that is likely to continue indefinitely. (Exhibit 2, page 1).

15. With respect to substantial functional limitations in major life activities, the assessment further provided:

Self care limitations:	
Language limitations:	
Learning limitations:	Mild mental retardation [redacted] Learning in this range indicates [Appellant] falls in the range of at least two standard deviations below the mean of the adult population.

Mobility limitations:	
Self direction limitations:	[Appellant] is significantly below his age range in making age appropriate decisions. He is unable to provide informed consent for health or personal care, legal habilitative, or financial issues. Father reports that [Appellant] functions for the majority at the [redacted] year age mark.
Independent Living limitations:	[Appellant] is unable to prepare food, pay bills and presents a significant danger to self without supervision.
Economic limitations:	[Appellant] is an adult who receives disability benefits and is unable to work without supervision without more than [redacted] hours a week and is paid less than minimum wage at his sheltered employment setting.

Exhibit 2, pages 1-2

16. Based on the above findings, the LLMSW that the CMH continue services, including case management, transportation and medication services, for Appellant. (Exhibit 2, page 6 of 6).

17. However, based on Appellant's LOCUS score and his entire medical record, which showed improvement over the years, the CMH determined that Appellant no longer met the criteria for services through it. (Testimony of [redacted]).

18. On [redacted], the CMH sent Appellant written notice that his services would be terminated, effective [redacted] because he no longer meets the diagnostic criteria for treatment services. (Exhibit H, pages 1-2).

19. Appellant filed a local appeal through the CMH, which was heard on [redacted] and denied in a [redacted] letter by [redacted] (Exhibit I, pages 1-2).

20. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-7).

21. On [redacted], Appellant was discharged from services through the CMH. (Exhibit K, pages 1-2).

22. In the Discharge Summary, it was noted that Appellant was referred to his primary care physician for medications and that his case manager tried to work with [redacted] on a reduced rate for Appellant, but was unsuccessful. (Exhibit K, pages 1-2).

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 statutes, 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*

Additionally, 42 CFR 430.10 states:

> 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 also 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…
>
> *42 USC 1396n(b)*

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 (DHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Here, eligibility for services through the CMH is set by Department policy, as outlined in the Medicaid Provider Manual (MPM). Specifically, the MPM states in the pertinent part of the applicable version of the MPM that:

> **1.6 BENEFICIARY ELIGIBILITY**
>
> *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.

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	▪ 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

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 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.	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 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.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when 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. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual’s needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP

> contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.
>
> *MPM, April 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 3-4*
> *(Emphasis added by ALJ)*

The State of Michigan's Mental Health Code defines mental illness and serious emotional disturbance as follows:

> 2. "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
>
> a. A substance abuse disorder.
> b. A developmental disorder.
> c. "V" codes in the diagnostic and statistical manual of mental disorders.
>
> 3. "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental

> illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> a. A substance abuse disorder.
> b. A developmental disorder.
> c. A “V” code in the diagnostic and statistical manual of mental disorders.
>
> *MCL 330.1100d*

Additionally, with respect to developmental disabilities, the Mental Health Code also provides:

> (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.
>
> b. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific

> congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.
>
> *MCL 330.1100a(25)*

Pursuant to the above policies and statutes, the CMH terminated Appellant's services in this case. Specifically, its witnesses testified that, given Appellant's LOCUS score; his entire medical record, which showed improvement over the years; his current stability; and the minimal services Appellant has been receiving; Appellant no longer meets the above criteria for services through the CMH. The witnesses also noted that Appellant's primary care physician can take over Appellant's medication reviews and that the non-emergency transportation to [redacted] should not have been approved anyway given that Appellant was not receiving supported employment services.

In response, Appellant testified that he likes his life, his services through the CMH, and working at [redacted]. Appellant's father also testified that Appellant has been judged incapable of working independently and he continues to require supported employment. He also testified that, while Appellant's current supported employment is not provided through the CMH, the transportation to it remains necessary and that he and Appellant have repeatedly requested supported employment services through the CMH. Appellant's father further testified that, while Appellant has been stable for the last year or two, his services are what have helped him become stable and that he may get worse again if his services are terminated. Appellant's father also noted that Appellant continues to live in a group home and that the LOCUS score is just one person's opinion and an opinion where Appellant's father could justify changes in three areas.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in terminating his services.

With respect to eligibility on the basis that Appellant has a serious mental illness, the undersigned ALJ finds that Appellant has failed to meet his burden of proof. While Appellant was previously authorized for services as a person with a serious mental illness and it is undisputed that Appellant still has a diagnosable mental, behavioral, or emotional disorder affecting him for a sufficient period of time, *i.e.* his OCD, the record does not reflect that Appellant's diagnosis continues to result in a functional impairment that substantially interferes with or limits Appellant's functioning given Appellant's stability; his LOCUS score and the information that generated that score; and the minimal services he has been receiving. Moreover, while Appellant's father disputes the LOCUS score and asserts that he could identify three areas where it is wrong, he could not give any specific examples and he did not dispute that Appellant has been stable for the last year or two. Similarly, while the Psychosocial Assessment recommended that Appellant's services continue, it also provided that Appellant has

been stable for years and is receiving minimal services, including transportation that is not even covered and medication reviews that can be provided elsewhere. Rather than identifying any current issues, both Appellant's case manager, in the Psychosocial Assessment and Appellant's father, in his testimony, appear primarily concerned with Appellant regressing in the future and, while such future concerns are valid, the CMH must only look at Appellant's current circumstances and the record fails to reflect that Appellant meets the criteria for services as a person with a serious mental illness given his long-time stability and the minimal services he has been receiving.

With respect to eligibility based on a developmental disability, Appellant has met his burden of proving by a preponderance of the evidence that the CMH erred in terminating his services. The CMH correctly notes that Appellant was previously denied services on the basis that he was not a person with a developmental disability back in [redacted] and argues that, as the definition for a developmental disability found in the Mental Health Code requires that a developmental disability must have manifested before an individual is [redacted] years-old, the relevant information has not changed as Appellant was already much older than age [redacted] when his previous request was denied. Moreover, the undersigned ALJ previously accepted the CMH's argument given that Appellant never appealed that earlier denial and offered no basis during the hearing in this matter to revisit the earlier decision.

However, in light of the [redacted] Psychosocial Assessment that has now been entered into the record on remand and considered by the undersigned ALJ, he now concludes that the CMH's review was incomplete and that its decision must be reversed. While any severe and chronic condition must have manifested before Appellant turned [redacted] years-old and Appellant was already assessed and denied after that age, that does not mean that he can never meet the criteria as additional information can subsequently be provided and circumstances can change. That is particularly true in this case as the [redacted] assessment did not appear to find that Appellant failed to manifest his condition prior to age [redacted] and instead based the denial on the finding that Appellant did not have a substantial functional limitation any of the seven areas of major life activity identified in the Mental Health Code at that time. Now, given that assessment and its recommendations, Appellant has again requested services on the basis that he was a person with a developmental disability and there is at least a basis for revisiting the earlier decision as the [redacted] Psychosocial Assessment found that Appellant is an individual older than five years of age who has a severe and chronic condition that is attributable to a mental and/or physical impairment, that is likely to continue indefinitely, and that has resulted in substantial functional limitations in four areas of major life activity: learning, self-direction, capacity for independent living, and economic self-sufficiency. Nevertheless, the CMH did not provide the assessment to MAHS prior the previous hearing or address its findings prior to the denial. Instead, the CMH just improperly relied on the [redacted] determination and, by doing so, it erred. Accordingly, the CMH's decision should be reversed and Appellant reassessed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly terminated Appellant's services.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED**.

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

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [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.