RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 23, 2016
MAHS Docket No.: 16-005737
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. [redacted] appeared on behalf of the Petitioner. [redacted], appeared as a witness for the Petitioner. [redacted], attorney, appeared on behalf of the Department. [redacted], Program Supervisor, appeared as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly terminate Petitioner's CMH services because it determined the Petitioner 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. Petitioner is a twenty-three year-old Medicaid beneficiary who has been diagnosed with Attention Deficit Disorder and Borderline Intellectual Functioning. Petitioner has a FSIQ score of 79, placing him in the low normal IQ range. (Exhibit A, pp. 1, 10; Testimony).

2. On [redacted], the Petitioner requested continued supports coordination services. (Exhibit A, p. 10; Testimony).

3. As of [redacted], the Petitioner was living at home with his family and receiving Social Security Income (SSI) in the amount of $[redacted] a month. (Exhibit A, p. 10; Testimony).

4. As of [redacted], the Petitioner was able to complete tasks of daily living with some prompting; able to be alone for significant portions of the day; able to prepare simple foods; understands money and can complete simple transactions; is able to make himself understood and can express his wishes, needs and ideas clearly; and is able to navigate within his community by walking or taking his bike. (Exhibit A, pp. 10, 11; Testimony).

5. As of [redacted], the Petitioner had a court appointed guardian. (Exhibit A, p. 11; Testimony).

6. The Petitioner graduated from high school with the some special education supports after having briefly attended [redacted]. The Petitioner did not find [redacted] to be challenging which necessitated the change. (Exhibit A, p. 11; Testimony).

7. In [redacted] and [redacted], the Petitioner was found to be eligible for services. Both of these admissions were terminated by the Petitioner's guardian and/or at the Petitioner's request. (Exhibit A, p. 11; Testimony).

8. As recently as [redacted], the Petitioner was found to be eligible for services. These services were set to expire on [redacted]. (Exhibit A, p. 11; Testimony).

9. On or around [redacted], the Department's Access Team, reviewed the Petitioners [redacted] request. (Exhibit A, p. 10; Testimony).

10. On [redacted], the Department issued a notice denying the Petitioner's [redacted] request for continued supports coordination services. (Exhibit A, pp. 6, 10; Testimony).

11. On [redacted], the Petitioner requested a local dispute resolution hearing. (Exhibit A, p. 10; Testimony).

12. On [redacted], a local dispute resolution hearing took place. (Exhibit A, p. 10; Testimony).

13. On [redacted], a fair hearings officer issued a findings and recommendation indicating the denial of supports coordination services was appropriate. (Exhibit A, pp. 10-13; Testimony).

14. On [redacted], the Michigan Administrative Hearings System (MAHS)

received from the Petitioner a request for hearing. (Exhibit A, p. 8).

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 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.	• 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 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 Department's witness indicated that the Michigan Mental Health Code definition of developmental disability was utilized by the Department to determine Petitioner 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*

The Department's witness testified that the [redacted] makes eligibility and level of care determinations for persons who request services and for the continuation of services. The witness testified the Petitioner 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.

Petitioner's witnesses testified the Petitioner did have substantial functional limitations in at least three areas. To corroborate these claims, the Petitioner's witnesses focused on the fact the Petitioner graduated from high school but only at the request of the Petitioner's parents. The witnesses did not identify how the diploma received was any different than any other diploma.

Based on the evidence presented, Petitioner did not prove, by a preponderance of the evidence, that the denial of requested CMH services was improper. The evidence shows Petitioner required a low level of support and that his need for support did not rise to the level of substantial functional limitations in at least three or more areas as required by the Mental Health Code.

As such, the Department was correct in determining the Petitioner 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 Petitioner'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 the Petitioner was not eligible for CMH services as a person with a Developmental Disability.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

CA/[redacted]

Corey Arendt
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS Hearing Rep. [redacted]

DHHS-Location Contact [redacted]

Petitioner [redacted]