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: July 28, 2016
MAHS Docket No.: 16-007439
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 Petitioner's request for a hearing.

After due notice, a hearing was held on July 27, 2016. Petitioner appeared and testified on her own behalf. [redacted], family friend and landlord, appeared as a witness for Petitioner.

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

ISSUE

Did the Department properly terminate Petitioner's CMH services because it determined that 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 [redacted] Medicaid beneficiary, born [redacted], who is diagnosed with Asperger's, Pervasive develop NOS, or Rhett's Disorder. (Exhibit A, p 32; Testimony)

2. For the past few months, Petitioner has been residing with a family friend who has a 36 year old son with Autism. Petitioner pays $300 per month in rent to the family friend. Prior to this arrangement, Petitioner lived with her parents, but they moved unexpectedly and required Petitioner to find her own place to live. (Exhibit A, p 33; Testimony)

3. Petitioner recently obtained her GED and was accepted into a Graphic Design program. Petitioner previously attended [redacted] in the Autistic Impaired program. (Exhibit A, pp 16, 33; Testimony)

4. Petitioner is her own guardian. Petitioner's full scale IQ is 82. Petitioner is independent in ambulation and enjoys walking in the neighborhood. Petitioner has a driver's license and can access the community. Petitioner can also access public transportation when needed. Petitioner has a long work history and has held some jobs for long periods of time. Petitioner is currently seeking employment. (Exhibit A, p 17, 33; Testimony)

5. Petitioner is independent with her Activities of Daily Living (ADL's). Petitioner can prepare her own meals and is independent in grooming, hygiene and all self-care skills. Petitioner is independent in expressive and receptive language and she has no medical concerns. (Exhibit A, pp 17, 33; Testimony)

6. Petitioner displays verbal and physical aggression when she does not get what she wants. Behavioral services have been in place for many years, but Petitioner has made few gains or improvements. Petitioner has difficulty managing her money and paying her bills. (Exhibit A, pp 17, 33; Testimony)

7. On [redacted], CMH's provider conducted an Annual Assessment with Petitioner. Following the screening, CMH's provider concluded that Petitioner no longer met the criteria for services as someone with a DD because she did not have a substantial limitation in three or more areas of major life activities. CMH's provider determined that Petitioner only had a substantial limitation in two areas of major life activities, namely self-direction and economic self-sufficiency. (Exhibit A, pp 10-34; Testimony)

8. On [redacted] and [redacted], CMH sent Petitioner notices indicating that her services would be terminated effective [redacted] and [redacted] respectively because she no longer met the criteria for coverage as a person with a developmental disability. (Exhibit A, pp 5-6; Testimony)

9. On [redacted] Petitioner's request for hearing was received by the Michigan Administrative Hearing System. (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
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
April 1, 2016, 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.
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> 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	• 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

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 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
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
April 1, 2016, p 3

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

> (25) “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 reviewed Petitioner's diagnoses and abilities. CMH's Access Center Manager reviewed the definition of Developmental Disability from the mental health code and concluded that Petitioner was not eligible for services as a person with a Developmental Disability (DD) because she 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 areas of major life activity where Petitioner had a substantial limitation were in the areas of self-direction and economic self-sufficiency.

Petitioner's friend and landlord testified that she has observed Petitioner since she came to live with her and her son a few months ago and that Petitioner cannot live on her own. Petitioner's friend and landlord indicated that Petitioner was forced to be her own guardian and cannot live independently. Petitioner's friend and landlord testified that Petitioner's parents had helped her immensely, but now that Petitioner does not live with them, Petitioner needs assistance. Petitioner's friend and landlord indicated that Petitioner needs to be reevaluated because a mistake has been made. Petitioner's friend and landlord testified that Petitioner's parents still control Petitioner's money and that Petitioner pays her $300 a month in rent. Petitioner's friend and landlord also indicated that Petitioner had an auto accident last winter and is not a safe driver. Petitioner's friend and landlord testified that Petitioner got her license through the [redacted], not through regular channels.

Petitioner testified that just because she has a driver's license does not mean that she can drive all the time. Petitioner indicated that her Mom can be a pain, always forcing supervision on her when she does not need it. Petitioner indicated that she receives $753 per month in SSI and SSDI and that the money is direct deposited into a joint account she shares with her parents. Petitioner indicated that she is her own guardian.

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 that Petitioner is independent in ambulation and enjoys walking in the neighborhood. Petitioner is her own guardian. Petitioner has a driver's license and can access the community. Petitioner can also access public transportation when needed. Petitioner has a long work history and has held some jobs for long periods of time. Petitioner is currently seeking employment. Petitioner is independent with her Activities of Daily Living (ADL's). Petitioner can prepare her own meals and is independent in grooming, hygiene and all self-care skills. Petitioner is independent in expressive and receptive language and she has no medical concerns. And while Petitioner needs significant assistance with self-direction and economic self-sufficiency, she does not have a substantial limitation in the areas of self-care, receptive or expressive language, learning, mobility, or capacity for independent living.

As such, CMH was correct in determining that Petitioner was not eligible for services as a person with a Developmental Disability (DD) because she did not have a substantial functional limitation in three or more areas of major life activities. Accordingly, the CMH's termination of Petitioner's 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 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.

RM/cg

Robert J. Meade
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

Agency Representative [redacted]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]

Petitioner [redacted]