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: March 10, 2017
MAHS Docket No.: 17-000754
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 upon Petitioner's request for a hearing.

After due notice, a hearing was held on March 9, 2017. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf.

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

ISSUE

Did the CMH properly deny Petitioner's request for Wraparound services and refer Petitioner to services through the Autism Benefit?

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 an [redacted] year old Medicaid beneficiary, born [redacted], receiving services through [redacted] County Community Mental Health (CMH). (Exhibit A, p. 11; Testimony)

2. CMH is under contract with the Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony)

3. Petitioner is diagnosed with autistic disorder, attention deficit hyperactivity disorder, and localization related symptomatic epilepsy and epileptic syndromes with simple partial seizures. (Exhibit A, pp. 23, 38; Testimony)

4. Petitioner has a documented history of verbal aggression and violence towards family members and he also talks about suicide, homicide and has engaged in injurious behavior directed toward his family members and himself. Petitioner reports audio and visual hallucinations and has a history of inpatient hospitalizations for treatment. (Exhibit A, pp. 23-26; Testimony)

5. Petitioner lives in a residential home with his mother and four siblings. (Exhibit A, p. 17; Testimony)

6. Petitioner attends [redacted] Elementary School in [redacted], Michigan where he is in the Autistic Impaired program. (Exhibit A, p. 23; Testimony)

7. Between October 2015 and August 2016, Petitioner was receiving Wraparound services through the CMH. Sometime thereafter, the family relocated to [redacted] County and Wraparound services were discontinued. In January 2017, Petitioner's family relocated back to [redacted] County and requested a new authorization for Wraparound services. (Exhibit A, pp. 11-A, 13; Testimony)

8. Following a review of Petitioner's request by the CMH Access Center, Petitioner's request for Wraparound services was denied as the CMH determined that it would be more clinically appropriate, given Petitioner's diagnosis and behaviors, for him to receive services through the Autism Benefit. (Exhibit A, p. 7; Testimony)

9. On January 7, 2017, CMH sent Petitioner an Adequate Action Notice informing him that the request for Wraparound services had been denied, but that services were being offered through the Autism Benefit. (Exhibit A, pp. 7-9; Testimony)

10. On January 27, 2017, 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. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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
January 1, 2017, pp 12-14

CMH's Program Supervisor testified that Petitioner presents with a primary diagnosis of autism and would be better served through the Autism Benefit. CMH's Program Supervisor indicated that while Petitioner did receive Wraparound services in the past that was mostly due to the fact that the Autism Benefit was not available to persons over six years old at that time. CMH's Program Supervisor testified that since the Autism Benefit has now been expanded to persons up to 21 years old, it would be clinically more appropriate for Petitioner to receive services through the Autism Benefit. CMH's Program Supervisor pointed out that services through the Autism Benefit are actually more intense than Wraparound services and the persons providing the services are more highly trained in the Autism Benefit area. CMH's Program Supervisor also indicated that since Petitioner had previously received services through the CMH, the CMH was aware of Petitioner's needs and what would work best for him.

Petitioner's mother testified that no one really explained to her what the difference was between Wraparound and Autism services so she became very concerned when

Wraparound was denied. Petitioner's mother pointed out that this whole situation could have been avoided if the CMH had simply let her use Petitioner's father's address for Petitioner when she was having housing issues. Petitioner's mother testified that she worked so hard to get the Wraparound services in place the first time, and Petitioner did so well in the program, she did not want him to have to go to a different program. Petitioner's mother indicated that when the services stopped, Petitioner really declined quickly. Petitioner's mother indicated that Petitioner is higher functioning on the autism scale so she is worried that services through the autism benefit may be too intense for him. Petitioner's mother testified that she is Petitioner's only support as her parents are dead and she also has other children to care for and raise. Petitioner's mother indicated that all she wants is help.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in denying Wraparound services and referring Petitioner to services through the Autism Benefit. Based on the evidence presented, Petitioner has failed to meet this burden. As the CMH pointed out, Petitioner's primary diagnosis is autism and he likely would have initially received services through the Autism Benefit but for the fact that the benefit did not cover children Petitioner's age at that time. Furthermore, services through the Autism Benefit are actually more intense than Wraparound services and the persons providing the services are more highly trained in the autism benefit area. As CMH's Program Supervisor pointed out, those services will be designed to meet Petitioner's individual needs, so there is little risk that the services would be too intense. Petitioner's primary diagnosis through his school district is also autism and he attends an autism program at school. As such, it is determined that the CMH properly denied Petitioner Wraparound services and referred Petitioner for services through the Autism Benefit.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner Wraparound services and referred Petitioner for services through the Autism Benefit.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

RM/sb

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]