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[redacted] MI [redacted]

Date Mailed: July 26, 2022
MOAHR Docket No.: 22-002560
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, 42 CFR 431.200, *et seq*. and 42 CFR 438.400, *et seq*. upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on July 19, 2022. [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf. [redacted] neighbor, appeared as a witness for Petitioner.

Katherine Squire, Fair Hearing Officer, appeared and testified on behalf of the Respondent, Community Mental Health for Central Michigan (CMH or Department).

ISSUE

Did the Department properly transition Petitioner from Home Based Services to Case Management?

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 Medicaid beneficiary who suffers from behavior problems and moderate mood disturbance. (Exhibit A, p 19; Testimony).

2. Petitioner had been receiving Home Based Services through CMH. (Exhibit A, p 1; Testimony).

3. The threshold to receive Home Based Services is a Child and Adolescent Functional Assessment Score (CAFAS) of 80 or particular severe subscales. (Exhibit A, pp 1, 18; Testimony).

4. Petitioner's CAFAS has been below 80 since February 2, 2022, and her last severe subscale score was at intake on December 4, 2020. (Exhibit A, pp 19-22; Testimony).

5. On May 12, 2022, Petitioner's mother filed an internal appeal to challenge the transition from Home Based Services to Case Management. (Exhibit A, pp 7-10; Testimony).

6. On May 18, 2022, CMH sent Petitioner's mother a notice denying the internal appeal. (Exhibit A, pp 2-6; Testimony). The Notice indicated, in pertinent part:

> A review was completed by a clinician who is not part of the current treatment team. The reviewer found in agreement of the original determination of transferring [sic] from Home Based services to Case Management. The decision was based upon a chart review where the only current PCP goal of "to be more independent" with related objectives. Progress notes indicate progress in this area and indicate that the family is able to manage behaviors and generally the family's report has been that things are going well. It shows therapy goals have been met at this time.
>
> CAFAS score: CAFAS score has been below 80 since 2/2/22. Last severe subscale score was at intake on 12/4/20. Typically the threshold for HB is CAFAS of 80 or particular severe subscales. The only CAFAS since intake to meet the 80 score was on 11/4/21. The MPM allows for a three month transition period out of HB which should have begun when CAFAS fell below 80 on 2/2/22. This transition period would now be complete.
>
> Currently the only services authorized are Home Based, health services, and respite at Cran Hill Ranch. A case manager would be able to provide check ins with the family for coordination and monitoring of these services since therapy goals have been met.
>
> (Exhibit A, p 2; Testimony).

7. On June 14, 2022, the Michigan Office of Administrative Hearings and Rules received Petitioner's hearing request. (Exhibit 1)[1].

[1] Petitioner's request for hearing was not offered or accepted on the record but admitted by the ALJ following the hearing when it was realized the request was not part of Respondent's hearing packet.

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 title, may waive such requirements of section 1902 (other than subsection (s)) (other than sections 1902(a)(15), 1902(bb), and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C) 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 Michigan Department of Health and Human Services (MDHHS) 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**
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> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
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> **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;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- 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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- 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;

  - that are experimental or investigational in nature;

  - 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.

* * *

With regard to Home Based Services, the Medicaid Provider Manual indicates:

> **7.2.C. AGE SEVEN THROUGH SEVENTEEN**
>
> **NOTE:** For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21.
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> Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven through seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.
>
> *Medicaid Provider Manual*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *April 1, 2022, pp 14-16; 58*
> *Emphasis added*

CMH's Fair Hearing Officer (FHO) testified that Petitioner had been receiving Home Based Services through CMH since approximately December 2020. CMH's FHO indicated that the threshold to receive Home Based Services is a CAFAS of 80 or particular severe subscales, but Petitioner's CAFAS has been below 80 since February 2, 2022, and her last severe subscale score was at intake on December 4, 2020. CMH's FHO indicated that Petitioner's psychiatric and respite services remain in place and her case manager can assist the family with accessing those services. CMH's FHO noted that the only current PCP goal was "to be more independent" and progress notes indicate progress in this area and that the family is able to manage Petitioner's behaviors.

Petitioner's mother testified that the family cannot manage Petitioner's behaviors at home and her behaviors are actually getting worse these days. Petitioner's mother indicated that Petitioner's behaviors are explosive and that the police were at her home the day prior to the hearing due to Petitioner's behaviors. Petitioner's mother testified that if they ask Petitioner to do anything, she becomes confrontational or will sit in a chair and refuse to move. Petitioner's mother indicated that she had to wrestle Petitioner's phone away from her on the day the police were called. Petitioner's mother noted that this is the fourth time the police have been out to the home due to Petitioner's behaviors. Petitioner's mother testified that Petitioner has not learned how to accept

responsibility for her own behaviors, and she blames everyone but herself for problems that arise. Petitioner's mother indicated that the home based therapist informed her that they stopped home based therapy because Petitioner refused to talk about her past, not because her therapy goals were met.

Petitioner's mother testified that they saw Petitioner's doctor on the day of the hearing and all he is going to do is increase Petitioner's Zoloft. Petitioner's mother indicated that the doctor told her that the home based therapist should have taught them how to deal with Petitioner, but she did not. Petitioner's mother noted that if Petitioner refused to talk about her past, the therapist would just take her out to do fun things, which was what Petitioner wanted. Petitioner's mother also indicated that the therapist never worked with the family at all, just with Petitioner. Petitioner's mother testified that Petitioner's maturity level is that of a 12-year-old. Petitioner's mother testified that they really need Home Based Services and really need a therapist that will work with the family too.

Petitioner's neighbor testified that she was outside walking her dog the day before the hearing when she heard someone screaming. Petitioner's neighbor indicated that she called Petitioner's mother and could hear Petitioner screaming so loud in the background it was incoherent, like a primal scream. Petitioner's neighbor testified that she was the one who called the police because it sounded so bad. Petitioner's neighbor indicated that this is a repetitive thing with Petitioner – she is loud and explosive until someone in authority shows up – then it is always someone else's fault.

Based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the CMH erred in transitioning her from Home Based Services to Case Management. As indicated above, the threshold to receive Home Based Services is a CAFAS of 80 or severe subscales, and Petitioner's CAFAS has been below 80 since February 2, 2022, and her last severe subscale score was at intake on December 4, 2020. While policy does allow a three-month period to transition out of Home Based Services, that period has passed since Petitioner last qualified for Home Based Services in February 2022. And, while it seems there may be a disconnect between the information in Petitioner's chart (that the family can manage her behaviors, that things are going well, and that therapy goals are met), the CMH can only base its decision on the information available to it. According to that information, Petitioner is no longer eligible for Home Based Services. With that said, based on the testimony of Petitioner's mother, it appears that Petitioner and her family would likely be eligible to receive therapy, just not in the home. The undersigned would suggest that Petitioner's mother speak to her case manager and request both individual therapy for Petitioner and family therapy. However, based on the evidence, CMH's decision was proper and 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 transitioned Petitioner from Home Based Services to Case Management.

IT IS THEREFORE ORDERED that:

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

RM/tem

Robert J. Meade
Administrative Law Judge

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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

Via Electronic Mail:

DHHS Dept Contact
Belinda Hawks
MDHHS
320 S. Walnut St., 5th Floor
Lansing, MI 48933
MDHHS-BHDDA-Hearing-Notices@michigan.gov
HawksB@michigan.gov

DHHS Department Rep.
Katherine Squire
CMH for Central Michigan
301 South Crapo, Suite 100
Mount Pleasant, MI 48858
KSquire@cmhcm.org
LAllbee@cmhcm.org

Via First Class Mail:

Petitioner
[redacted]
[redacted] MI [redacted]

Authorized Hearing Rep.
[redacted]
[redacted] MI [redacted]