STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted]
Appellant

_____/

Docket No. 2009-10062 CMH
Case No. [redacted]
Load [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. The Appellant was present and testified. He was represented by [redacted]. [redacted], represented the Department. His witness was [redacted].

ISSUE

Did the Department properly deny services owing to the existence of "benefits through the Veteran's administration?"

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted]-year-old ABW beneficiary.

2. He is enrolled in [redacted] and receives VA benefits. (*See* Appellant's Exhibit #1 and Testimony)

3. The Appellant is afflicted with long standing "SP disorder" [Schizoid Personality], mood swings, poor memory and depression. He hears things. He said he was told by the VA that he needs counseling. (*See* Testimony of Appellant)

4. Appellant lives in [redacted] and cannot arrange transportation to Saginaw for VA services.

5. The Appellant takes a host of medications including Trazodone, Omeprazole Divalproex, and Lisinopril and others which require quarterly review by a physican. (*See* Testimony of Appellant)

6. [redacted] is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

7. The Appellant stated that he desired to seek CMH services because he knows he needs counseling and regular medications. He added that he is unable to get to the VA for lack of transportation and/or the mental capacity to remember distant appointments. (*See* Testimony and Appellant's Exhibit #1)

8. The Department witness stated that Medicaid is the payor of last resort and referred the Appellant to the Department of Human Services for transportation. (*See* Testimony and Department's Exhibit A, p. 3)

9. The Appellant was noticed of the denial on [redacted]. (Department's Exhibit A, p. 2)

10. The instant appeal was received by SOAHR on [redacted]. (Appellant's 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

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…

Section 1915(c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). [redacted] (the Department) contracts with the Michigan Department of Community Health to provide those services.

While it is axiomatic that Medicaid is the payer of last resort the CMH is the entry point for treatment of serious and persistent mental illness. The service criteria for this capitated provider is medical necessity.

In this case there was no known screening of the Appellant to assess the nature and severity of his mental illness. Indeed, the testimony of the Appellant and his lay representative established a framework for the diagnosis of a severe and persistent mental illness of Major depression and Schizoid Personality. *See* Testimony of Appellant.

Although it was determined that the Appellant has Veterans Administration insurance there was no evidence or discussion on the parity of those mental health services - an important consideration as the CMH could be responsible for gap-filling if the Appellant decided to utilize his VA benefit for inapposite mental health care – which he is not required to pursue irrespective of coordination of benefits.[1]

In performing the terms of its contract with the Department, the Community Mental Health Service Provider (CMHSP), must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **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.

[1]. . . . The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual. MPM Mental Health [ ] §1.1, page 1, January 1, 2009.

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/CMHSP

Supports, services, and treatment authorized by the PIHP/CMHSP 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/CMHSP DECISIONS

Using criteria for medical necessity, a PIHP/CMHSP 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.

MPM, Mental Health [ ];
§2.5 pp. 11 -13, January 1, 2009

As of [redacted] the Appellant is an ABW beneficiary. As such, he is entitled to those services afforded to ABW beneficiaries. Coverage and limitations follows (entire list not included by ALJ):

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service Coverage

Ambulance Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).

Case Management Non-covered

Chiropractor Non-covered

Dental Non-covered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.

Emergency Department Covered per current Medicaid policy. For CHPs, PA may be required for non-emergency services provided in the emergency department.

Eyeglasses Non-covered

Family Planning Covered. Services may be provided through referral to local Title X designated Family Planning Program.

Hearing Aids Non-covered

Home Health Non-covered

Home Help (personal care) Non-covered

Hospice Non-covered

Inpatient Hospital Non-covered

Lab & X-Ray Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.

….

Mental Health Services Covered: Services must be provided through the PIHP/CMHSP …

….

Outpatient Hospital (No emergency Department) Covered: Diagnostic and treatment services and diabetes education services PA may be required for some services. A $3 co-payment for professional services is required. Noncovered: Therapies, labor room and partial hospitalization.

*** * ***

[ ] MENTAL HEALTH/SUBSTANCE ABUSE COVERAGE

Mental health and substance abuse services for ABW beneficiaries are the responsibility of the Prepaid Inpatient Health Plans (PIHPs) and the Community Mental Health Services Programs (CMHSPs) as outlined in this section.

ABW mental health and substance abuse coverage is limited both in scope and amount to those that are medically necessary and conform to professionally accepted standards of care consistent with the Michigan Mental Health Code. Utilization control procedures, consistent with the medical necessity criteria/service selection guidelines specified by MDCH and in best practice standards, must be used.

[ ] MENTAL HEALTH SERVICES

PIHPs/CMHSPs are responsible for the provision of the following mental health services to ABW beneficiaries when medically necessary and within applicable benefit restrictions:

- Crisis interventions for mental health-related emergency situations and/or conditions.
- Identification, assessment and diagnostic evaluation to determine the beneficiary's mental health status, condition and specific needs.
- Inpatient hospital psychiatric care for mentally ill beneficiaries who require care in a 24-hour medically-structured and supervised licensed facility.
- Other medically necessary mental health services:
- Psychotherapy or counseling (individual, family, group) when indicated;
- Interpretation or explanation of results of psychiatric examination, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the beneficiary;
- Pharmacological management, including prescription, administration, and review of medication use and effects; or
- Specialized community mental health clinical and rehabilitation services, including case management, psychosocial interventions and other community supports, as medically necessary, and when utilized as an approved alternative to more restrictive care or placement.

Any beneficiary liability for the cost of covered services shall be determined by each CMHSP, according to the ability-to-pay provisions of the Michigan Mental Health Code and applicable administrative rules.

(Emphasis supplied) MPM, Adult Benefit Waiver §§2 and 3, January 1, 2009, pages 4-8

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The Appellant established by a preponderance of the evidence that he was a person with a severe and persistent mental illness.

The testimony established that the Appellant is in need of services, but is unable to access them through the Veteran's Administration. The Appellant wants to avoid travel to [redacted] but little else is known about the specifics of the Appellant's affliction or his proposed treatment regiment – if any.

The CMH witness was correct that Medicaid is the payer of last resort. He correctly acknowledged on questioning from the ALJ that the CMH is the entry point for mental health services in the State of Michigan. However, the CMH is allocated general funds to meet its legislative mandate to serve the needs of those with serious mental illness – irrespective of Medicaid status. *See* MCL 330.1208 (1) and 330.1100c (6)

The Appellant cannot be compelled to accept VA services.

Furthermore, there is no information in this record about the scope of those VA services and their suitability for one afflicted with a severe and persistent, mental illness. Absent that knowledge about whether those services are duplicative to that which the CMH might be required to offer or whether those mental health services are, in deed, efficacious – the CMH remains responsible for the provision of services not provided by others.

Assuming medical necessity the Appellant is free to seek those services whenever he wants – so long as he is not receiving duplicate services elsewhere. There was no evidence to suggest that he was doing so or that he would receive duplicate services based on this record.

Absent evidence that the VA benefits were duplicative the CMH was in error to simply shift services to others without a more searching inquiry.[2] The CMH has deferred service for which they might well be responsible.

The Appellant has preponderated his burden of proof that he is one afflicted with a mental illness now seeking treatment.

The Department's action was not proper when made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly denied access to services.

[2] There was no evidence of the screening process or how the CMH reconciled services presumed to be offered by the VA in comparison with those services available to him under CMH. *See* Testimony.

IT IS THEREFORE ORDERED that

The Department's decision is REVERSED.

IT IS FURTHER ORDERED that

The Department shall prepare an IPOS within 30-days receipt of this Decision and Order.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/12/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.