STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-23289 CMH
Case No. [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 [redacted]. [redacted] was present and represented herself at hearing.

[redacted] for [redacted] represented the Community Mental Health authority for the Department of Community Health. [redacted] was present on behalf of the CMHSP.

ISSUE

Does the Appellant meet the MDCH/CMHSP Managed Specialty Supports and Services Contract Medicaid service eligibility requirements for mental health services?

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 Medicaid beneficiary.

2. [redacted] (hereinafter CMHSP) - is a CMHSP.

3. The Appellant sought services from CMHSP on [redacted], at an intake.

4. The Appellant was assessed on or about [redacted], resulting in an AXIS I diagnosis of psychotic disorder, NOS and alcohol dependence, with physiological dependence.

5. The Appellant resides in the community in her own apartment. She has RSDI/SSI income benefits as well as health care benefits. The Appellant uses public transportation, shops, cooks and cleans for herself.

6. The Appellant was appropriately dressed and groomed at her assessment. Her attitude was pleasant and cooperative, motor activity calm and appropriate.

7. The Appellant had spontaneous speech with normal rate and tone at her assessment.

8. The Appellant self reported depression and anxiety, as well as a history of hearing voices.

9. The Appellant reported past episodes of violence, all linked to consumption of alcohol.

10. The Appellant reported no current suicidal plan or intent at the [redacted] assessment.

11. The Appellant has psychotropic medication prescribed for her by her primary care physician.

12. The Appellant sought case and medication management services at her intake.

13. The CMHSP determined as a result of her intake that the Appellant did not meet eligibility criteria to receive services through the CMHSP, due to lack of severity of symptoms.

14. The CMHSP informed the Appellant she did not meet eligibility criteria, denied her request for services and offered a second opinion.

15. The Appellant participated in a second assessment [redacted].

16. The second assessment resulted in Axis I diagnosis consistent with the first assessment. Axis I diagnosis included: alcohol dependence, anxiety disorder NOS, Mood disorder NOS, Tricholillomania, Psychosis NOS.

17. The Appellant has a historical diagnosis of schizophrenia, per evaluation at jail. The two assessments conducted by the CMHSP disagreed with the schizophrenia diagnosis following full assessments and found the Appellant's reports were inconsistent with a diagnosis of schizophrenia.

18. The second assessment found the Appellant did not meet full criteria for major depressive disorder.

19. The Appellant presented to the second assessment as a self sufficient high functioning woman with a low intensity of needs. The assessment found she has insurance and would benefit from medication monitoring and therapy available through the benefits offered through her insurer. She did not meet criteria for case management services due to lack of severity of symptoms.

20. The Appellant was denied case management and medication management services.

21. The Appellant's request for hearing was received on [redacted].

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.
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> *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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. [redacted] contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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 *MDCH/CMHSP Managed Specialty Supports and Services Contract* (the Contract)*: Attachment 3.3.2, 10/1/02, page 35,* makes the distinction that a person must have a persistent mental illness and/or severe emotional disturbance, as opposed to having only mild or moderate psychiatric symptoms, in order to be eligible to receive Medicaid specialized mental health services through a CMHSP. In the Contract, persistent mental illness and severe emotional disturbance are defined by:

> diagnosis and degree of disability, or
> diagnosis and duration of illness, or
> diagnosis and prior service utilization criteria.

The Department's Contract with the CMH sets out the eligibility requirements for Medicaid specialized ambulatory mental health benefits. Severe and Persistent Mental Illness is defined in the Contract as:

> 1. Diagnoses as defined by Diagnostic and Statistical Manual-IV Version (DSM-IV)- Schizophrenia and Other Psychotic Disorder (295.xx; 297.1; 297.3: 298.8: 298.9), Mood Disorders, or Major Depressions and Bipolar Disorders 296.xx).
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> 2. Degree of Disability-Substantial disability/ functional impairment in three of more primary aspects of daily living such that self-sufficiency is markedly reduced. This includes:
>
> > Personal hygiene and self-care,
> > Self-direction,
> > Activities of daily living,
> > Learning and recreation, or
> > Social transactions and interpersonal relationships.

In older persons (55 or older), loss of functional capacity might also include:

Loss of mobility.
Sensory impairment,
Physical stamina to perform activities of daily living or ability to communicate
Immediate needs as the result of medical conditions requiring professional supervision, or
conditions resulting from long-term institutionalization.

Duration-

a) evidence of six continuous months of illness, symptomatogy, or dysfunction, or six cumulative months of symptomatology/dysfunction in a 12-month period, or

b) based on current conditions and diagnosis, there is a reasonable expectation that the symptoms/dysfunctions will continue for more than six months.

Prior Service Utilization-

a) four or more admissions to a community inpatient unit/facility in a calendar year, or
b) community inpatient hospital days of care in a calendar year exceeding 30 days, or
c) State hospital utilization of over 60 days in a calendar year, or
d) Utilization of over 20 mental health visits (e.g., individual or group therapy) in a calendar year.

MDCH/CMHSP Managed Specialty Supports and Services Contract: Attachment 3.3.2, 10/1/02, pages 35-36.

In this case there is disagreement between the parties regarding whether the Appellant is schizophrenic or not. It is not necessary to determine with certainty whether the Appellant has a diagnosis of schizophrenia or mood disorder NOS, anxiety disorder NOS given the evidence tending to show a lack of severity of symptoms. The material issue in this case is whether she is exhibiting symptoms sufficiently severe to meet the eligibility criteria set forth above. There is no credible evidence she does experience severe symptoms such that she meets qualifying criteria as of the time of the two evaluations. The uncontested material evidence of record establishes she does not exhibit a degree of disability, duration or prior service utilization that is a requisite of the criteria. Diagnosis alone will not satisfy the qualifying criteria as set forth above. As noted in the above Contract language, in addition to the diagnosis criterion the Appellant must also meet either the degree of disability, duration of illness or prior service utilization criteria in order to meet the definition of severe and persistent mental illness and therefore be eligible for CMH Medicaid services.

The evidence of record concerning the remaining criteria is discussed below.

Degree of disability criterion – Using the evaluations performed by the CMHSP, there is not a preponderance of evidence she suffers marked or severe impairment with her ADL's, personal hygiene or self care, self direction, social interactions or learning and recreation. Nor is there a preponderance of evidence she has suffered Loss of mobility, Sensory impairment, has problems with physical stamina to perform activities of daily living or ability to communicate immediate needs as the result of medical conditions requiring professional supervision, or has any condition resulting from long-term institutionalization. The evidence of record is that she has a neat appearance and her dress, hygiene and self care are all appropriate. She is self sufficient and does not require case management services to accomplish self care tasks or maintain social and personal relationships. She is able to access recreation and is not learning impaired.

Based on the uncontested evidence of record, it was established that Appellant had not met the degree of disability criterion.

Duration of illness criterion – The uncontested evidence of record established the Appellant is stable, her condition being described as adequately controlled with her medication. There was no evidence presented that the preceeding year had episodes where the Appellant was exhibiting signs and symptoms of severe or marked dysfunction. There is no evidence upon which this ALJ could base a finding the Appellant has satisfied this criteria.

Prior service utilization criterion – The Appellant has not had any psychiatric hospitalizations in her past. There is no evidence the Appellant had four or more admissions to a community inpatient facility, had been in a community hospital for more than 30 days, had not been in a state hospital for more than 60 days and had utilized more than 20 mental health visits in the past calendar year. Again, there is no evidence of record that Appellant had met the prior service utilization criterion.

The CMHSP provided credible evidence that the Appellant does not meet the MDCH/CMHSP Managed Specialty Supports and Services Contract eligibility requirements for a severe and persistent mental illness and sent proper notice of service termination. The Appellant did not provide a preponderance of evidence that she met the MDCH/CMHSP Managed Specialty Supports and Services Contract eligibility requirements for receiving CMH Medicaid services as a person with a severe and persistent mental illness.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Appellant does not meet the MDCH/CMHSP Managed Specialty Supports and Services Contract Medicaid service eligibility requirements for mental health services.

IT IS THEREFORE ORDERED that:

The CMHSP's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/10/2009

***** NOTICE *****

SOAHR 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 SOAHR 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.