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. 2009-30970 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 on [redacted]. [redacted], Appellant's authorized representative, appeared and testified on Appellant's behalf. [redacted] (Appellant) appeared at the hearing but did not testify. [redacted], Assistant Corporate Counsel, represented the Department's agent, [redacted]). [redacted], Access Center Manager, appeared and testified as a witness for the Department.

ISSUE

Did the Department[redacted] properly determine that Appellant no longer met the eligibility requirements for Medicaid-covered specialized 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 [redacted] Medicaid beneficiary who is enrolled in a Medicaid Health Plan.

2. [redacted]) is a Prepaid Inpatient Health Plan (PIHP) under contract with the Michigan Department

of Community Health (Department) to provide Medicaid covered services to Medicaid beneficiaries who reside in the [redacted] service area.

3. Appellant had been receiving Medicaid-covered specialized mental health services, outpatient mental health and medication management services, through MCCMH since the [redacted]. (Exhibit 1, p. 1)

4. Appellant has a history of depression, paranoia, auditory hallucinations, and delusions. (Exhibit 1, p. 20/Attachment D)

5. According to progress notes from [redacted] Appellant did not have any psychotic symptoms or suicidal/homicidal ideations; there was no evidence that he was paranoid or delusional; and Appellant was taking his medications. (Exhibit 1, pp. 49-60)

6. An [redacted] annual assessment of Appellant completed on [redacted], revealed the following: Appellant was well-groomed with normal speech and thought content; Appellant was oriented to person, time and place or fully oriented; Appellant's memory, abstraction, judgment, and insight were intact; Appellant had average intelligence; Appellant was considered anxious with a loose thought process, agitated motor activity, and labile affect; Appellant did not have a problem with substance abuse; there was no history or evidence of current homicidal/suicidal thoughts, urges, plans or behaviors; there was no evidence of a history of violent or assaultive behavior; and Appellant was not on psychotropic medications. (Exhibit 1, pp. 14-20/Attachment D)

7. On [redacted] Appellant was given an Axis I diagnosis of major depression with psychotic features and a global assessment of functioning score of [redacted]. (Exhibit 1, p. 20/Attachment D)

8. On [redacted], [redacted] sent Appellant written notice that he was no longer eligible for Medicaid-covered specialized mental health services through [redacted]. (Exhibit 1, pp. 4-6)

9. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for hearing, protesting the denial of CMH services.

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. NorthCare contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by the CMH agency 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.*

In this case, Appellant had been receiving Medicaid-covered specialized mental health services, outpatient mental health and medication management services, through [redacted] since the [redacted]. On [redacted] notified Appellant in writing that he was no longer eligible for specialized mental health services. According to the [redacted] witness, Appellant is able to receive the mental health services that he needs through his Medicaid Health Plan.

> **1.6 BENEFICIARY ELIGIBILITY**
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> 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.
>
> 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:

- 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 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.

In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:

- 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 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.
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> *Medicaid Provider Manual, Mental Health/Substance Abuse, Section, effective April 1, 2009*

The Department established that Appellant has not been seriously mentally ill or seriously emotionally disturbed with a substantial impairment in his ability to perform activities of daily living within the last year. Further, there is no evidence that Appellant continues to have residual symptoms or a serious mental impairment which requires specialized mental health services. Progress notes from [redacted] through [redacted] revealed that: Appellant did not have any psychotic symptoms or suicidal/homicidal ideations; there was no evidence that he was paranoid or delusional; and Appellant was taking his medications. An [redacted] annual assessment of Appellant completed on [redacted], revealed the following: Appellant was well-groomed with normal speech and thought content; Appellant was fully oriented; Appellant's memory, abstraction, judgment, and insight were intact; Appellant had average intelligence; Appellant was considered anxious with a loose thought process, agitated motor activity, and labile affect; Appellant did not have a problem with substance abuse; there was no history or evidence of current homicidal/suicidal thoughts, urges, plans or behaviors; there was no evidence of a history of violent or assaultive behavior; and Appellant was not on psychotropic medications. Lastly, there is no evidence on the record to establish that Appellant has been treated by his Medicaid Health Plan (MHP) for mild or moderate psychiatric symptoms and limited functional impairments and has exhausted the 20-visit maximum for the calendar year. Therefore, the Department[redacted]s eligibility determination 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[redacted] properly determined that Appellant no longer met the eligibility requirements for Medicaid-covered specialized mental health services.

[redacted]
Docket No. 2009-30970 CMH
Decision and Order

IT IS THEREFORE ORDERED that:

The Department's/[redacted] decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/27/2009

***** 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.