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

Docket No. 2010-25107 CMH
Case [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. [redacted] was represented by his father, [redacted] His cousin, [redacted] was also presented and testified on his behalf. The Appellant was present at hearing.

[redacted] (CMH), represented the Department. [redacted], appeared as a witness on behalf of the Department. [redacted], was present as a Department witness. [redacted], also appeared as a witness.

ISSUE

Did CMH properly terminate psychiatric services (medication review) for the Appellant?

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 Medicaid beneficiary.

2. The Appellant is enrolled in a Medicaid Health Plan and has been a participant in Community Mental Health services since [redacted].

3. [redacted] (CMH) is a CMHSP.

4. The Appellant has been receiving psychiatric services (medication review) from the CMH during the last service year.

5. The Appellant has an Axis I diagnosis of Schizo-affective disorder. He has had only one (1) psychiatric in patient admission, in [redacted] He has had no hospitalizations since the [redacted] admission.

6. The Appellant takes medication for his psychiatric diagnosis and has had no medication changes since [redacted]

7. The Appellant is functionally and psychiatrically stable.

8. The only service the Appellant has been receiving from CMH is medication review with a psychiatrist.

9. The Appellant has no current mental health related complaints.

10. The Appellant's most recent utilization management review states the Appellant's functioning level and service level are incongruent due to his stability and lack of specialty service needs.

11. The Appellant does not have a need for specialty mental health services. His psychiatric need of medication review can be met by utilization of his health plan mental health benefits.

12. The Appellant was notified in [redacted] his psychiatric services would be terminated. He requested a local appeal. The local appeal affirmed the termination decision.

13. 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, Sections 2.0 and 3.1* and Attachment 3.1.1, Section III(a) Access Standards-*10/1/08, page 4,* directs a CMH to the Department's Medicaid Provider Manual for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6 makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

1.6 BENEFICIARY ELIGIBILITY

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.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. 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:	**In general, PIHPs/CMHSPs 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 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 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	□ 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

months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2009, page 3.

The Department witness testified that CMH utilized *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6, July 1, 2009, page* 3 to determine the Appellant did not meet the eligibility for specialized mental health services provided through the CMH. In particular, the witness asserted the Appellant fell into the category of MHP responsibility. The specific language Medicaid Provider Manual Section 1.6 language CMH relied on is underlined directly above and its arguments are individually listed below.

Mild and moderate symptoms -

The CMH does not dispute that Appellant has schizo-affective disorder. Rather, the CMH position is that the Appellant is not eligible for CMH Medicaid services because he has no need for specialty services. He is psychiatrically stable without medication change for five (5) years. He has minimal needs that are adequately addressed by utilization of his health plan's mental health services. He participates in medication management services, which can be provided by a psychiatrist or primary care physician who participates with his Medicaid Heath Plan. It is asserted he does not exhibit signs and symptoms of a serious mental illness such that he requires ongoing specialty supports and services to be provided by the CMH. His functional status is cited as the evidence of mild degree of signs and symptoms.

The Appellant did not provide any evidence of serious signs or symptoms he has experienced in the recent past. There is no evidence presented to refute the claim that he is high functioning and has been over the most recent service year. The Appellant did assert he is stable due to the treatment and medication he receives from his psychiatrist. He is comfortable

and close with his treating psychiatrist and does not want to change. He is worried about possible decompensation or having to change medications if he has to change providers.

Stable –

A review of evidence presented, including the utilization management review and testimony offered by the Appellant establishes it is not medically necessary to authorize specialty supports and services in order to maintain the Appellant's stable psychiatric status. The Appellant is psychiatrically stable and presented no evidence to refute the evidence presented by the CMH.

No specialized supports and services –

The [redacted] provided credible evidence that the Appellant meets the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that he met the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the CMH.

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 Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 05/27/2010

***** 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.