STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-44017 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]. Appellant [redacted] appeared on her own behalf.

[redacted] (CMH), represented the CMH. [redacted]; and [redacted] appeared and provided testimony for the CMH.

ISSUE

Did CMH properly determine that Appellant did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH?

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. (Exhibit B).

2. The Appellant is enrolled in a Medicaid Health Plan, [redacted]. (Exhibit B).

3. Appellant had been receiving services from [redacted] since at least [redacted]. (Exhibit B). Appellant had been receiving services for post-traumatic stress disorder, bipolar disorder and depression, including the medication Celexa, from [redacted]. (Exhibit B).

4. In [redacted], Appellant requested CMH services from [redacted]. (Exhibits B and D).

5. On [redacted], Appellant was provided an initial assessment. (Exhibit B). The CMH assessment rated Appellant's Functional Impairments of Life Domains as: family and interpersonal relationships - moderate, personal hygiene and self-care - none, activities of daily living - mild, learning and recreational or vocational - mild, self-direction - mild, finances/entitlements - unknown. (Exhibit B, pages 12-13).

6. Overall findings from Appellant's [redacted], assessment were that her functional impairments were mild to moderate. The Clinician's Interpretive Summary stated, "At this time, client is not eligible for AMHS. She is quite capable and able to utilize available community providers for supports." (Exhibit B, page 13).

7. The Appellant requested a Second Opinion Assessment. On [redacted], the Second Opinion Assessment was performed and rated Appellant's Functional Impairments of Life Domains as: family and interpersonal relationships - moderate, personal hygiene and self-care - none, activities of daily living - mild, learning and recreational or vocational - moderate, self-direction - moderate, finances/entitlements - unknown. (Exhibit D, page 9).

8. Overall findings from Appellant's [redacted], assessment were that her functional impairments were mild to moderate. The Clinician's Interpretive Summary stated, "It is also recommended client connect with the community therapist to address for PTSD, and enhance her coping skills to increase her ability to manage life stressors as they arise… At this time, client does not meet criteria for SPMI diagnosis so therefore is not eligible for services at this time." (Exhibit D, page 10).

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating that her psychiatric services would be denied. (Exhibit E).

10. The Appellant's request for hearing was received on [redacted]. (Exhibit A).

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 she 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] CMH 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 CMH representative [redacted], stated that the Appellant requested CMH services and was provided an initial assessment on [redacted]. (Exhibit B.) The CMH representative explained the assessment process used by the CMH, elaborating that the guidelines and service matrix are

similar to the service selection guidelines previously included in the DCH-CMH contract and provide a uniform framework from which to assess applicants as objectively as possible. (Exhibits E and F). The CMH introduced document evidence of the ratings derived during the assessment for Appellant's Life Domains as:

> Family and interpersonal relationships - moderate,
> personal hygiene and self-care - none,
> activities of daily living - mild,
> learning and recreational or vocational - moderate,
> self-direction - moderate,
> finances/entitlements - unknown. (Exhibit B, pages 12-13)

The CMH representative explained that the assessment's overall findings were that the Appellant's functional impairments were mild to moderate. The CMH representative further explained that the CMH must follow the Department's Medicaid Provider Manual, its contract with the Department, when seeking guidance for its responsibility to provide mental health services to an applicant.

The *MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1* and Exhibit 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 outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

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 was formerly significantly or seriously mentally ill at some point in the past.	□ 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

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.	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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2010, page 3.

CMH witness [redacted] stated that CMH utilized *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6, July 1, 2010,* page 3 to determine it was more appropriate for the Appellant to receive mental health services through her MHP than to receive specialized mental health services provided through the CMH. (Exhibit H). In particular, CMH witness [redacted] testified the Appellant was assessed with only mild or moderate functional impairments in life domains and therefore fell squarely into the category of MHP responsibility. The Medicaid Provider Manual (MPM) Section 1.6 language CMH relied on is underlined directly above. Utilizing the evidence submitted by the CMH and applying it to the Medicaid Provider Manual's Section 1.6 responsibility framework demonstrates that the CMH determination that the Appellant did not qualify for CMH specialty adult health services was proper.

It is noted that the evidence also demonstrates that after the [redacted] initial assessment and adequate action notice, the CMH performed a second opinion assessment for the Appellant at the end of [redacted], which also demonstrated the Appellant only had mild to moderate symptoms.

The Appellant testified that she had been receiving community mental health services in [redacted] for at least [redacted]. The Appellant explained that she had been receiving community mental health services in the form of therapy for post-traumatic stress disorder and depression. The Appellant stated that she has previously been hospitalized for mental health services. The Appellant said she preferred mental health services from CMH instead of a Medicaid health plan because she felt that a CMH understood mental illness better than did a Medicaid health plan. The Appellant requested a second opinion assessment as well as a request for an administrative hearing.

The CMH representative and witness [redacted] explained that the Appellant's Medicaid health plan includes 20 mental health services visits for people with mild or moderate symptoms. The CMH representative explained that although the Appellant scored as a person who is high functioning and able to secure her basic needs, she does have a need for routine and non-specialized mental health services, but there are other routine, and non-specialized treatment options available for her in a Medicaid health plan which bears the treatment responsibility for mild to moderate symptoms.

[redacted] CMH provided credible evidence that the Appellant did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that she met the Medicaid Provider Manual eligibility requirements for Medicaid specialized outpatient mental health benefits provided through the CMH.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/4/2010

***** 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.