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

IN THE MATTER OF

Appellant

________________________/

Docket No. 2010-45022 CMH

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 . The record was left open until to receive a written closing from the Appellant. The Department declined the invitation to provide a written closing. The Appellant appeared without representation. Her witness was . , attorney, represented the Department. His witnesses were; Fair Hearings Officer, , Access Center Clinician, and , Access Program Director.

ISSUE

Did the Community Mental health of (CMH) properly deny services as requested by 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 Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is homeless. (*See* Testimony)

3. She was recently disenrolled from , but remains eligible for FFS Medicaid and is eligible to re-enroll in MHP as of . (Department's Exhibit A, pp. 15, 16)

4. On , the Appellant was screened for service eligibility and found to be ineligible for psychiatric and case management – accordingly, services were denied. (Department's Exhibit A, pp. 1 – 8 and *See* Testimony of)

5. An internal appeal brought by the Appellant confirmed the results obtained by clinician on . (*See* Department's Exhibit A, pp. 8 – 10 and *See* Testimony of)

6. The Appellant was notified of her denial and her further right to appeal. (Department's Exhibit A, pp. 11 – 14)

7. During her testimony at hearing on the Appellant appeared agitated and threatened suicide. (*See* Testimony of i)

8. On assessment the Appellant is diagnosed with Major Depressive Disorder, Recurrent Mild; Personality Disorder NOS; paranoid, narcissistic, histrionic with HTN, chronic pain and shingles. (Department's Exhibit A, p. 2)

9. The Appellant was hospitalized in following a Christmas Eve overdose. She saw [psychiatrist] between . The record suggests that the Appellant was non-compliant with medication and individual therapy – although the Appellant testified otherwise today. (Department's Exhibit A, p. 2 and *See* Testimony of the Appellant)

10. The instant appeal was received by the State Office of Administrative Hearings and Rules (SOAHR) on . (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). Community Mental Health of Ottawa County (CMH) contracts with the Michigan Department of Community Health to provide those services.

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 (MPM), Mental Health Chapter makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits.

The MPM sets out the eligibility requirements as follows:

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 <u>mild or moderate</u> 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 <u>minimal clinical (self/other harm risk) instability</u>. 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.	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.

MPM, Mental Health and [ ], Beneficiary Eligibility §1.6, July 1, 2010, page 3.

CMH witnesses testified that CMH determined on clinical screening ad local appeal that the Appellant did not meet the eligibility standards for specialized and intensive mental health services provided through the CMH. Both witnesses remarked that the Appellant fell into the category for MHP responsibility.

The specific language relied upon by the CMH is underlined above and discussed here:

Mild and moderate symptoms -

The CMH does not dispute that the Appellant has a diagnosis. They determined her diagnosis to be Major Depressive Disorder, Recurrent Mild and Personality Disorder NOS and/or [on second opinion] they further determined that the Appellant did not meet criteria for Paranoid Personality Disorder, Schizotypal Personality Disorder, Schizoid Personality Disorder, Narcissistic Personality Disorder and Borderline Personality Disorder. [See Department's Exhibit A at pages 8 through 10 and Testimony of

The consensus of the CMH witnesses was that the Appellant would benefit from MHP services.

The Appellant was highly critical of the CMH and rejected their reviews. She said. "… if I wasn't seriously [disturbed] then why do I want to step in front of a f****** truck - because I am sick and tired." She said further that she felt she was being neglected earlier by when her appointments were "pushed back." She said today that she did not realize that was sick herself.

On review, the evidence supports the "moderate" diagnosis reached by the CMH on initial assessment. While obviously quarrelsome I believe the Appellant's testimony promises future compliance with process, [including medication].

The Department's assessment of no serious mental illness is supported in the record – but the CMH is reminded that its contract with the Michigan Department of Community Health through the Medicaid Provider Manual also requires them to assist their beneficiaries in accessing Medicaid services.[2] A moderately symptomatic beneficiary with the aggravating features presented by this Appellant obviously requires greater effort.[3]

The CMH is allocated general funds to meet its legislative mandate to serve the needs of those afflicted with serious mental illness – irrespective of Medicaid status. *See* MCL 330.1208 (1) and 330.1100c (6)

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[1] The ALJ observes that on second opinion several of the criteria were at or close to "threshold" on CS II ES Categorical Summary Report, Department's Exhibit A, pp. 8, 9.

[2] *See* MPM, [Mental Health] §3, Covered Services, July 1, 2010 at page 15.

[3] *See* MPM, [Mental Health]§1.6, Beneficiary Eligibility, July 1, 2010 at page 4, which states in pertinent part: The critical clinical decision-making processes should be based on the local agreement, common sense and the best treatment path for the beneficiary." Emphasis added by ALJ

Because the CMH remains the entry point for mental health services in (assuming future medical necessity) the Appellant is free to seek those services whenever she wants – so long as she is not receiving duplicate services elsewhere. In this case, the evidence preponderates that her impairment is moderate and thus subject to the treatment rubric available through her MHP.

The Appellant has not preponderated her burden of proof that she is one afflicted with a serious mental illness.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that the Appellant was not eligible for services through the CMH.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc:

Date Mailed: 10/20/2010

***** 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.