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

[redacted]
Appellant

_____/

Docket No. 2010-49419 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]. The Appellant appeared without representation. Her witness was her daughter, [redacted]. [redacted], attorney, represented the Department. His witnesses were [redacted] and [redacted], RN.

ISSUE

Did the Department properly terminate case management, psychiatric and nursing services 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. At the time of hearing the Appellant is a [redacted] spend down Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with: bipolar disorder, severe depression, borderline personality disorder, fibromyalgia with chronic pain. (Appellant's Exhibit #1)

3. On [redacted], the Appellant was notified that her services, case management, psychiatric and nursing would be terminated effective the date of appeal as the Department had determined on review that the Appellant no

longer met medical necessity for those services. (See Testimony of [redacted] and Department's Exhibit A, pp. 6-14)

4. The Appellant's internal appeal affirmed the department and set forth her further appeal rights in detail. (Department's Exhibit A, sub B, pp. 15, 16)

5. The review conducted by Hall showed the Appellant functioning at independence level 1 as of [redacted]. According to [redacted] this represented the lowest possible level of service need – and indicated that her needs could be met elsewhere. The Department, according to [redacted], typically serves individuals with higher levels of need. (See Testimony of [redacted])

6. A long time recipient of case management services [redacted] with her last psychiatric hospitalization in [redacted] the Appellant was "linked" to the [redacted] for psychiatric services and pharmacy services.

7. She was advised in writing that the [redacted] clinician would accept her Medicare benefit as coverage. (Department's Exhibit A, p. 4)

8. The Department believes that the Appellant has been stable for two years and is capable of meeting her needs in the community through use of her Medicare benefit and peer support services. (Department's Exhibit A, p. 5)

9. The Appellant filed the instant request for hearing, as received by SOAHR, on [redacted]. (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

> 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 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 (Department) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW.

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 (MPM) for determining both the receipt or discontinuance of services – such as case management, psychiatric and nursing services utilized by the Appellant in what the Department believes to have been the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.[1]

[1] 42 CFR 440.230

The receipt of these intensive, individually tailored and medically necessary services[2] and supports are designed for those who function with a high level of vulnerability requiring a constant continuum of mental health services from the PIHP and who evidence an inability to independently access and sustain involvement with needed services. Today, the Department asserts that the Appellant is ready to cast that continuum of services aside and make it – more or less - on her own initiative with help from the community, family and friends.

The Department's evidence was compelling. The Appellant has made significant progress with her mental afflictions. She has not been hospitalized – she has used the case management service for 5-years.

At hearing the Appellant, although tearful, presents as an insightful and intelligent woman. She has legitimate concern for her future and the future of her daughters – she worries about the residuals of her past conduct on her daughters future growth – in turn they worry about her.

There was no testimony from the Appellant or her daughter, however, which persuaded this reviewer that she was debilitated with ongoing mental illness of a sort that requires the level of service to which she has become accustom.

There is reason for caution to be sure; the holidays approach, a recent spending error has put her finances in turmoil. These are not insurmountable issues – but rather the every day stuff that confronts everyone. <u>If there are significant problems the Appellant is familiar enough with the system that she knows how to reenter for emergency services.</u>

However, the testimony did highlight a concern with the "linked" services at [redacted] apparently unknown to the Department. The Appellant said the service was exceedingly abrupt and not what she expected. Gauging from the testimony of the Department witnesses – it was not what they expected to hear back from their referral either.

So while the Department has persuaded the ALJ that they properly terminated the Appellant's case management, psychiatric and nursing services - those services are continued until the next review period to give the Department an opportunity to further investigate the worth of the "linked" services established for the Appellant.[3]

Medicaid beneficiaries are only entitled to medically necessary, Medicaid covered services. 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.

[2] See MPM, Section 13 generally [redacted], p. 67
[3] If this goes beyond a perception issue presumably the Department will want to reestablish links for the Appellant elsewhere.

With documentation of stability apparent in the record as reflected on 6-month assessment the Appellant no longer meets medical necessity criteria for Case Management, psychiatric or nursing services. Furthermore, based on the documentation the Appellant has demonstrated medication stability, general improvement in condition, the absence of depression and a lack of recent hospitalization.

The Appellant did not preponderate as one afflicted with a serious mental illness requiring Case Management.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant no longer met the requirements for Case Management.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED pending resolution of referral issue.

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

cc: [redacted]

Date Mailed: 11/15/2010

***** 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.