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. 2010-4970 CMH
Case No. [redacted]

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 on [redacted]. [redacted], appeared on behalf of the Appellant. The Appellant was present and provided testimony. [redacted] represented the CMH. [redacted] appeared as witnesses for the CMH.

ISSUE

Did CMH properly terminate Appellant's case management 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.

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

3. Appellant was receiving services from CMH in [redacted]. (Exhibits A, B). Appellant was receiving case management services through CMH in [redacted]. (Exhibits A, B).

4. In [redacted] CMH listed Appellant as having no Axis I diagnosis, but an Axis II diagnosis of 317.0 Mild Mental Retardation. (Exhibits A, B).

5. On [redacted] the Appellant called CMH and left a message saying she wanted to close her CMH case services. (Exhibit B).

6. On [redacted], the Appellant called CMH and said she wanted to close her CMH case. (Exhibit B). During the call the Appellant said she did not agree with her mild mental retardation diagnosis. (Exhibit A).

7. As a result of Appellant's [redacted], requests to close her mental health services the CMH closed her case. (Exhibit C).

8. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating that her case management services would be terminated. (Exhibit C).

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

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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. 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.

The Appellant clearly and competently testified at hearing and stated in her request for hearing that the reason she called to close her case was because she was offended by the CMH diagnosis of "mild mental retardation."

The CMH representative said that because the Appellant asked twice for her CMH case to be closed, her case management services, the only services she was currently receiving, were terminated. The CMH explained that the Appellant could request mental health services through her [redacted].

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 case management 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	□ 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

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.	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.

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

During the hearing the CMH introduced evidence of the fact that after Appellant's CMH case was closed in [redacted], she called the CMH for an intake assessment on [redacted]. (Exhibits D, E). The CMH explained that CMH set up two appointments for her to attend an inperson assessment for services but the Appellant failed to appear for both appointments. This [redacted] intake issue occurred subsequent to Appellant's request for hearing. The jurisdiction of this ALJ is with the [redacted] action of the CMH and no issues after that date. For this reason this ALJ does not have jurisdiction to decide any issue related to Appellant's [redacted].

CMH provided credible evidence that its [redacted] termination of case management services, based on the fact that Appellant asked twice for her case to be closed, was not improper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

The CMH's termination of Appellant's case management services was proper.

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: 1/13/2010

***** 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.