**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

[redacted],
**Appellant**

_____/

**Docket No.** [redacted]
**Case No.** 58594902

## 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]. [redacted] appeared on his own behalf. [redacted], provided testimony.

[redacted], represented the Department. [redacted], and [redacted], appeared as witnesses for the CMH/Department.

## ISSUE

Did CMH properly terminate Appellant's case management and supported employment 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 Medicare and has social security income.

3. Appellant has been receiving services from CMH since at least [redacted]

4. Appellant's [redacted] psychological evaluation indicated he had an Axis I diagnosis of major depressive disorder an Axis Ii diagnosis of antisocial personality disorder. (Attachment M).

5. In [redacted], [redacted] opined that the Appellant had the capacity to live independently. (Exhibit M).

6. In [redacted], a semi-annual person centered plan review was performed for the Appellant using the LOCUS (level of care utilization system) assessment tool. (Exhibit E and F).

7. The level of care utilization system assessment results were a score of 13 and showed the Appellant did not meet the criteria to receive case management and supported employment services. (Exhibit J).

8. On [redacted], the CMH sent an Advance Action Notice to the Appellant indicating that his case management and supported employment would be terminated effective [redacted]. (Exhibit G). The reason CMH gave for terminating services was because the Appellant's level of care utilization system score was 13, indicating he no longer met the criteria for CMH services. (Exhibit G).

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

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 sets forth 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.<br><br>☐ 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).<br><br>☐ 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.<br><br>☐ 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.*

CMH witnesses [redacted] testified that a level of care utilization system tool was used to perform a semiannual assessment for the Appellant. The CMH witnesses explained that the level of care utilization tool assess the Appellant in six dimensions: risk of harm, functional status, medical, addictive and psychiatric co-morbidity, recovery and environment or level of stress and level of support and treatment and recovery/engagement. (Exhibit E and F). The CMH witness [redacted] testified that the results of the level of care utilization tool demonstrated that the Appellant did not meet the criteria for case management and supported employment services.

In particular, witness [redacted] testified that the Appellant's score was 13 and therefore did not demonstrate medical necessity. (Exhibit J). [redacted] explained that the CMH can only authorize Medicaid covered services if an Appellant meets the Medicaid medical necessity criteria. The Medicaid Provider Manual lists medical necessity as:

> **2.5.B. MEDICAL NECESSITY DETERMINATION CRITERIA**
>
> The determination of a medically necessary support, service or treatment must be:
>
> - Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
> - Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
> - For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
> - Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
> - Made within federal and state standards for timeliness; and
> - Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
> - Documented in the individual plan of service.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2010, page 13.*

The CMH witnesses explained each of the dimensions of the level of care tool, using evidence introduced into the record. (Exhibit F). It was explained that the tool is a guideline for ensuring all persons assessed by CMH are assessed using the same criteria. It was also demonstrated that scores of between a level 1 through 16 show mild to moderate symptoms.

[redacted] explained that with regard to the case management criteria, the CMH will look to see if there are community resources available to a person and whether that person is able to access that criteria, and it was determined that the Appellant's does have community resources available to him and he is able to access those resources. An example provided by the CMH is that the CMH walk-in clinic is available to Appellant at any time and he has accessed that resource in the past.

The Appellant stated that he was requesting the level of care tool be performed on him one more time. The Appellant explained that "things" have become worse for him since the last level of care assessment. An example given by Appellant is that the police were at his house the Sunday night before the hearing.

The Appellant and his mother stated that they didn't believe it was right that the Appellant's CMH services would be terminated. The Appellant's mother elaborated that the Appellant had been receiving CMH services since [redacted] and that he needs help with making good decisions. The Appellant's mother stated that in the Appellant's supported employment he cleans 40 toilets per day and takes pride in doing his job, and she is concerned that he will not be able to find a job if his supported employment is taken away.

The Appellant and his mother requested and were granted an opportunity to introduce a letter written by the Appellant's private pay psychiatrist a few days before the hearing. The Appellant and his mother emphasized that the psychiatrist stated the CMH test score for treatment and recovery are "unrealistic". (Exhibit 2).

This Administrative Law Judge's jurisdiction is limited to the information the CMH had at the time it made its determination that the Appellant no longer met medical necessity criteria for CMH case management and supported employment. For this reason, the Appellant's [redacted] psychiatrist letter was given limited weight.

The CMH demonstrated by credible evidence that it performed a proper medical necessity assessment for the Appellant, but the Appellant did not meet the criteria for CMH services. 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, decides that:

The CMH properly terminated Appellant's case management and supported employment services.

**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: 11/12/2010

***** 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.