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

IN THE MATTER OF:

Docket No. 2011-25152 CMH
Case No.

,

Appellant
_______________________/

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 . , the Appellant's mother, represented the Appellant at hearing. She does not serve as his legal guardian.

Community Mental Health, was present on behalf of the CMH. , was present on behalf of the CMH. , was present on behalf of the CMH. was present on behalf of the CMH. was present on behalf of the CMH. After due notice, a hearing was held .

ISSUE

Did CMH properly determine the Appellant does not meet services eligibility criteria as a person with a serious mental illness?

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 an year-old Medicaid beneficiary.

2. CMH is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. The Appellant is diagnosed with spina bifida, ADHD, oppositional defiant

disorder and a mood disorder. He has a normal I.Q.

4. The Appellant has been participating in Community Mental Health services for several years. His involvement started through the Wraparound services provided through the Department of Human Services. He has been receiving case management, clubhouse and psychiatric support services.

5. The CMH has completed a review of the Appellant's case and determined his adult functioning level was incongruent with his services level. It was further determined that he does not meet medical necessity criteria for mental health services. provided through the CMH.

6. The CMH notified the Appellant he did not meet the criteria for services on [redacted].

7. Referrals were made to other community resources to address the deficits exhibited by the Appellant and provide necessary psychiatric medications.

8. The Appellant's mother requested a local appeal of the aforementioned determination.

9. The CMH then conducted a Utilization Management Review for the Appellant. The prior determination was upheld.

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

11. The Appellant does not have a legal guardian and is responsible for his own decisions.

12. The Appellant's prior service plan included authorization for clubhouse utilization 1x per week, medication review 1x per quarter and case management contact 1x per month. The case management contact was with his mother.

13. The Appellant's latest assessment indicates some of the Appellant's goals had been met, primarily socialization and community participation. Other unmet goals were the result of lack of follow through i.e. ending school attendance prior to completion.

14. The Appellant's case management needs are being met by the natural support provided by his mother.

15. The Appellant can continue to be prescribed his psychiatric medication through use of his primary care physician.

16. The Appellant had attended Clubhouse 1x per month during the most

recent assessment period. He was socializing primarily through other outlets, such as with friends.

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.
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> *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.
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> *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 sections 1915(b) and 1915(c) Medicaid Managed Specialty Services waiver. Kalamazoo County CMH contracts with the Michigan Department of Community Health to provide specialty mental health services, including DD services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, October 1, 2009

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 makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

1.6 BENEFICIARY ELIGIBILITY

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of

this manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

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. 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	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.

services and supports.	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.

The CMH notified the Appellant his targeted case management services would be terminated. The Appellant objects to the termination of services. He is entitled to Medicaid funded services through CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH Medicaid Provider Manual guidelines.

2. The service in issue is a Medicaid covered service, i.e. State Medicaid Plan or waiver program service, and

3. The service is medically necessary.

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In this case the CMH determined that the Appellant did not meet criteria for specialized mental health services as an adult and that specialized services were not medically necessary. He was receiving authorization to participate in Clubhouse, medication review and targeted case management services. The targeted case management services were delivered via his mother due to his age at the time of service delivery. The Medicaid Provider Manual describes Targeted Case Management services below:

> **SECTION 13 – TARGETED CASE MANAGEMENT**
> Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning,

linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS
Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED
The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.

> **Documentation** The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs.
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> The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
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> **Monitoring** The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services. Targeted case management may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: July 1, 2009 Pages 67-68
Michigan Department of Community Health

Now that the Appellant is an adult, his need for services was reviewed. The Appellant is residing with friends after moving out of his family home. Primarily through his mother working with the former Case Manager and wraparound services he has been linked to the services he is availing himself of. He does not demonstrate a continued need for linking to services or other functions of case management at this time. He has already been linked to resources such as SSI and Medicaid and has been referred to peer support groups. He participates in community recreational opportunities without assistance or supervision. He can access his primary care physician with help from his mother in order to continue receiving psychiatric medications and other health care. His natural support system is meeting any case management needs at this time.

The Appellant had been authorized to participate in Clubhouse activities prior to becoming an adult. He had been attending Clubhouse 1x per month at the time of the most recent assessment. He voluntarily engages in recreation with his friends and family without assistance of CMH. He has his own peer group and social outlets as evidenced in the most recent assessment. He does not demonstrate a medical need for continued authorization of this service.

The Appellant was also authorized for psychiatric supports services, AKA medication reviews. This was authorized one (1) time per quarter. Upon review for service eligibility the CMH determined the Appellant is stable and compliant with psychiatric medication at this time. He does not exhibit a need for specialized service in the area beyond what could be provided by this primary care physician. The Appellant's mother contested the finding he is emotionally stable with testimony that he appears stable but really is not. She said he confides in her that he struggles. The CMH refuted with evidence that the Appellant has not had physically violent or aggressive outbursts during the most recent assessment period and that he is generally respectful of teachers and others although he may argue or fight with his brothers. The ALJ finds the evidence of a lack of aggression and violent outbursts as well as medication compliance is good evidence that the Appellant's current psychiatric needs can be met through the benefits available through the health plan as well as his need for medication refills. He is not actively having his medications adjusted in an effort to achieve psychiatric stability at this time, thus assertion he is stable is found reliable. The need for psychiatric medication review is not established as medically necessary.

SUMMARY

This ALJ finds there is insufficient evidence the Appellant satisfies the eligibility criteria for specialized mental health services provision at this time. If his needs change, he may seek evaluation of his eligibility and need for services at any time. Should he experience or believe he is in psychiatric crisis he should seek evaluation and services. He is not foreclosed from seeking assistance in the future based upon his most recent assessment.

DECISION AND ORDER

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

> The Appellant does not meet the Michigan Mental Health Code eligibility requirements for specialized mental health services provided through the CMH.

IT IS THEREFORE ORDERED that:

The CMH's termination of services is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 7/22/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.