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:

[redacted],

Docket No. 2011-36826 CMH
Case No. [redacted]

Appellant
_____/

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 [redacted] was represented by her mother, [redacted].

[redacted], Fair Hearing Officer for [redacted] represented the Department. [redacted], Access Center Clinician, appeared as a witness on behalf of the Department.

ISSUE

Did CMH properly determine the Appellant is ineligible for 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] year-old Medicaid beneficiary.

2. The Appellant is seeking services through the Community Mental Health access system as a person with a serious mental illness.

3. [redacted] (hereinafter the CMH) is the CMHSP which serves the Appellant's geographic area in the State of Michigan.

4. The Appellant has a current Axis I diagnosis of Schizo-affective disorder. She has had one (1) psychiatric in-patient admission, in [redacted]. She has had no hospitalizations since the [redacted] admission.

5. The Appellant sought services for assistance with housing services from [redacted]. She was assessed for services criteria on or about [redacted].

6. The Appellant reportedly takes medication for her psychiatric diagnosis.

7. The Appellant reports she is treating with a therapist at the [redacted].

8. The Appellant reported she has no suicidal ideation or history of attempts. She is not engaged self injurious behavior.

9. The Appellant's hygiene and self care are adequate. She makes and keeps her own psychiatric appointments and takes her medication without assistance.

10. The evaluation determined the Appellant has no homicidal ideation.

11. The Appellant did not report psychotic symptoms observed at her assessment. She denied history of psychotic symptoms but the CMH records reflected delusional thinking and paranoia in [redacted].

12. The Appellant did not report acute medical symptoms, substance abuse issues or other safety risk factors at the assessment.

13. The Appellant has no current mental health related complaints.

14. The Appellant maintains a cosmetology license and is self employed, renting a chair at a salon.

15. The Appellant assists with the family business, a retail store for Christian books and supplies.

16. The Appellant resides independently in the community in an apartment owned by her family.

17. The Appellant maintains a driver's license and does drive.

18. The Appellant's most recent utilization management review states the Appellant exhibits mild psychiatric symptoms as of the assessment date.

19. [redacted] determined the Appellant does not have a need for specialty mental health services.

20. The Appellant was notified she was denied specialty mental health services, specifically case management services, on or about [redacted].

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

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. Network 180 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 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.)	□ 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

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). <u>The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</u>	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.

The Department witness testified that the CMH used assessment criteria developed that is consistent with the criteria set forth in the *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6, July 1, 2009, page* 3 to determine the Appellant did not meet the eligibility for specialized mental health services provided through the CMH. In particular, the witness stated the criteria contained as assessment of the Appellant's status in the following areas:

> **Activities of daily living:** no evidence was presented at assessment or hearing that the Appellant has deficits related to self care, cleaning shopping or personal care. She has some economic considerations, which impact bill paying, but it was found to be mild, thus not within eligibility criteria.

Social Interaction: The Appellant did not report troubles with social interaction at assessment. This would measure her ability to interact effectively, to get along with family and community. Deficits would be reflected in history of altercations, firing, evictions and avoidance due to fear and isolation. Here, there is testimony the Appellant has some uncooperative behavior as reported by her mother. The examples included a willingness to communicate via text message, telling her mother to be quiet and failure to heed instruction from her mother relative to working at the store. None of the reported concerns evidence symptoms that could be attributed only to serious mental illness. Without some clinical or medical documentation to support an assertion that this conduct is evidence of serious mental illness, this ALJ cannot make such a finding.

Concentration, Persistence and Pace: No evidence was presented at hearing demonstrating the Appellant exhibits signs or symptoms of serious mental illness in this area. Deficits would be evidenced by inability to concentrate, complete simple tasks on time, committing frequent errors or requiring assistance in completing such tasks.

Adaptation to Change: Deficits in this area are evidenced by repeated failure to cope with stressful circumstances at work, school, family or social interactions. Unexpected change in environments may agitate or exacerbate signs/symptoms of illness or withdrawal from stressful situations. No evidence was presented demonstrating the Appellant exhibited any such signs at the time of assessment in [redacted].

Summary

The CMH does not dispute that Appellant has schizo-affective disorder. Rather, the CMH's position is that the Appellant is not eligible for CMH Medicaid services because she has no need for specialty services, based upon the finding she exhibits mild to moderate symptoms at the time of assessment. She is psychiatrically stable as of the assessment date. She is functional in the community setting where she resides. Her needs are being addressed by medication and counseling she obtains and arranges without assistance through her Medicaid Health Plan. It is asserted she does not exhibit signs and symptoms of a serious mental illness such that she requires ongoing specialty supports and services to be provided by the CMH. Her functional status is cited as the evidence of mild degree of signs and symptoms. The witness for the CMH further testified the Appellant was oriented to time, place and circumstance and could have had a psychiatric evaluation if she accepted the outpatient referral. She chose not to.

The Appellant's mother asserts the Appellant lacks insight into her true circumstances and will report her status more favorably than is the case. She asserted the Appellant's counselor telephoned her to tell her that her daughter's thinking is not reality based. She further testified her daughter cannot accept instructions from her at the family's retail store and tells her to be quiet. She further testified the Appellant will only communicate with her via text message. Furthermore, she is not making money at the salon where she rents her chair. She asserted she is concerned for her future and will not always be there for her as she is getting old.

A review of evidence presented, including the assessment and its criteria and testimony offered by both parties establishes it is not medically necessary to authorize specialty supports and services for the Appellant at the time of the most recent assessment.

The CMH provided credible evidence that the Appellant meets the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that she 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, finds that:

> The Appellant does not meet the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 8/31/2011

***** 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.