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],

Appellant

Docket No. 2012-3028 CMH
Case No. 1547662

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq*., upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Hearing Officer, represented the [redacted] Community Mental Health (CMH). [redacted], Social Worker, and [redacted], Director of [redacted], also testified as witnesses for the CMH.

ISSUE

Did the CMH properly terminate Appellant's psychiatric support 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. Appellant is a [redacted] year-old woman who has been diagnosed with post-traumatic stress disorder and dysthymic disorder. (Exhibit E, pages 12, 20).

2. Appellant is also a Medicaid beneficiary and has been receiving psychiatric support services through the CMH. (Exhibit E; Testimony of [redacted]).

3. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

4. With respect to her services, a progress note dated [redacted], stated that Appellant had only attended 3 of her 13 scheduled appointments in the past year and that only 1 appointment was cancelled by staff. (Exhibit E, page 8).

5. Other progress notes provided that Appellant subsequently cancelled appointments on [redacted], [redacted], [redacted], and [redacted]. (Exhibit E, pages 10, 18, 24-25). Similarly, Appellant failed to attend or call in for appointments on [redacted], [redacted], and [redacted]. (Exhibit E, pages 11, 26-27).

6. In the progress noted dated [redacted], it was noted that Appellant had not been seen by a physician since [redacted]. (Exhibit E, page 28).

7. As a result of Appellant's failure to attend appointment and utilize services, the CMH determined that her case should be closed. (Exhibit E, 28-30).

8. On [redacted], the CMH sent a notice to Appellant notifying her that her services were being terminated because "You have not attended a medication review since [redacted] [sic]. Since [redacted] there have been 2-cancellations and 2-no-shows. A previous Notice of Appeal was done in [redacted], you appealed the decision, it was approved for further services." (Exhibit C, page 1).

9. On [redacted], Appellant requested a local appeal regarding the termination of services. (Exhibit D, page 1).

10. That local appeal was subsequently denied. (Exhibit D, page 2).

11. On [redacted], the Department received Appellant's Request for Hearing with respect to the termination of services. (Exhibit A, page 1).

12. Appellant's services were continued pending the outcome of her appeals. (Exhibit E, page 30).

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 C.F.R. § 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 C.F.R. § 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…
>
> (42 U.S.C. § 1396n(b))

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. The CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the MI Choice waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230. The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits:

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.
- Documented in the individual plan of service.

(*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 13)*

Here, it is undisputed that Appellant missed a number of appointments as described above. Moreover, [redacted] credibly testified that, given Appellant's limited engagement with the CMH, Appellant was not receiving any intensive services as part of her program. (Testimony of [redacted]). [redacted] also testified that Appellant had not reported any psychiatric problems as a result of missing her appointments and that she is able to maintain her functioning at a high level without the CMH's services. (Testimony of [redacted]).

In response, Appellant testified that she does not go to appointments with her workers because they do not "click" with her. (Testimony of Appellant). (Testimony of Appellant). Appellant also testified that she sometimes has trouble getting gas money so that she can make her appointments. (Testimony of Appellant). Appellant further testified that she sometimes forgets about appointments. (Testimony of Appellant). According to Appellant, she does not like her medications because of their side effects, but that it is hard without them. (Testimony of Appellant).

Appellant must prove by a preponderance of evidence that the CMH termination of her services was not proper, but she is unable to do so here. The CMH provided credible evidence that its termination of psychiatric support services was proper given that Appellant failed to utilize those services over an extended period of time and without any adverse effects. Therefore, Appellant is unable to establish a medical necessity for the services and the CMH's decision must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly terminated Appellant's psychiatric support services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/6/2011

***** 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.