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) 373-4147

IN THE MATTER OF:

Docket No. 2013-56126 CMH

[redacted]

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 on [redacted] the Appellant, appeared on her own behalf.

[redacted], Corporate Counsel, represented the [redacted] Community Mental Health and Substance Abuse Services (CMH or Department). [redacted] Utilization Coordinator, appeared as a witness for the Department. [redacted] Customer Services Manager, and [redacted] Program Director, were also present.

The hearing record was left open through [redacted] for the Appellant to provide additional documentation, which was received. (Exhibit 4)

ISSUE

Did the CMH properly terminate the Appellant's [redacted] and [redacted] 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 who has been receiving [redacted] and [redacted] services through the CMH since approximately [redacted] (Exhibit 1, pages 1 and 9-10)

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

3. The Appellant has been diagnosed with major depressive disorder and bipolar II disorder. (Exhibit 1, page 7)

4. The Appellant lives in an apartment in [redacted] and is working on her GED by attending programming/classes at [redacted]. (Exhibit 1, page 10)

5. The CMH determined that the Appellant's individual therapy and [redacted] services should be terminated because the Appellant no longer met clinical eligibility criteria. (Exhibit 1, pages 1 and 6)

6. On [redacted], the Appellant requested a local appeal of the determination. (Exhibit 1, page 6)

7. On [redacted], a Utilization Management Review was completed. The Utilization Coordinator recommended that the termination of the Appellant's services be upheld. (Exhibit 1, pages 9-15)

8. On [redacted], the CMH sent an Appeal Disposition to Appellant stating the determination to terminate the individual therapy and [redacted] services was upheld because medical necessity for the services was not met. The notice stated that in reviewing the Appellant's records, it was evident that progress was made toward the goals and objectives in the Appellant's Plan of Service and with the gains she has made, the Appellant demonstrated she no longer requires specialty-level community mental health services. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pages 3-4)

9. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted] (Exhibit 1, page 5)

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

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.* Medical necessity is defined by the Medicaid Provider Manual 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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
    - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
April 1, 2013, Pages 12-14
(Underline added by ALJ)

Regarding Individual/Group Therapy services, the Medicaid Provider Manual states:

3.11 INDIVIDUAL/GROUP THERAPY

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
April 1, 2013, Page 18

Regarding Clubhouse services, the Medicaid Provider Manual states:

SECTION 5 – CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary (also called clubhouse "members"), with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community. Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

5.1 PROGRAM APPROVAL

PIHPs must seek approval for providers of psychosocial rehabilitation clubhouse services from MDCH. (Refer to the Directory Appendix for contact information.) MDCH approval will be based on adherence to the requirements outlined below.

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to-member ratio.

5.3 ESSENTIAL ELEMENTS

Member Choice/Involvement

- All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning.

- Members establish their own schedule of attendance and choose a unit that they will regularly participate in during the ordered day.
- Members are actively engaged and supported on a regular basis by clubhouse staff in the activities and tasks that they have chosen.
- Membership in the program and access to supportive services reflects the beneficiary's preferences and needs building on the person-centered planning process.
- Both formal and informal decision-making opportunities are part of the clubhouse units and program structures so that members can influence and shape program operations.

Informal Setting

- Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.
- Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and all holidays (including New Year's Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day).

Program Structure and Services

The program's structure and schedule identifies when the various program components occur, e.g., ordered-day, vocational/educational. Other activities, such as self-help groups and social activities shall be scheduled before and after the ordered day.

Ordered Day

The ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It is made up of those tasks and activities necessary for the operation of the clubhouse and typically occurs during normal work hours. The ordered day is carried out in organizational units defined by the clubhouse that accomplish the work necessary to operate the clubhouse and meet the community living needs of the members, such as housing and transportation. Although participation in the ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. Member

participation in the ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems.

Employment Services and Educational Supports
Services directly related to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, and supports for the completion or initiation of education or training and other vocational assistance must be available.

Member Supports
Opportunities for clubhouse members to provide and receive support in the community in areas of outreach, warm line, self-help groups, housing supports, entitlements, food, clothing and other basic necessities or assistance in locating community resources must be available.

Social Supports
Opportunities for members to develop a sense of a community through planning and organizing clubhouse social activities. This may also include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities.

5.4 PSYCHOSOCIAL REHABILITATION COMPONENTS
Following are some of the broad domains of psychosocial rehabilitative goals and objectives. Based on the member's individual plan of service developed through the person-centered planning process, these are carried out during the member's participation in the ordered day and through interactions with other staff and members. Staff may also work informally with members on individual goals while working side-by-side in the clubhouse.

Symptom Identification and Care

- Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses.
- Gaining competence regarding how to respond to a psychiatric crisis.

- Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well being.
- Working in partnership with members who express a desire to develop a crisis plan.

Competency Building

- Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment).
- Social and interpersonal abilities (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).
- Personal adjustment abilities (e.g., developing and enhancing personal abilities in handling every day experiences and crisis, such as stress management, leisure time management, coping with symptoms of mental illness). The goal of this is to reduce dependency on professional caregivers and to enhance independence.
- Cognitive and adult role competency (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).

Environmental Support

- Identification of existing natural supports for addressing personal needs (e.g., families, employers, and friends).
- Identification and development of organizational support, including such areas as sustaining personal entitlements, locating and using community resources or other supportive programs.

Medicaid Provider Manual, Mental Health and Substance Abuse Section, April 1, 2013, Pages 30-32.

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve her goals.

In response to the Appellant's request for a local appeal to contest the determination that her individual therapy and [redacted] serves should be terminated, Utilization Management Review was completed. The Utilization Coordinator is a limited licensed psychologist and certified advance alcohol and drug counselor. The Utilization Coordinator recommended the termination of the Appellant's services be upheld. (Exhibit 1, pages 9-15; Utilization Coordinator Testimony) The rationale noted:

> She has steady income and has her own apartment. She has not been hospitalized in many years and has no current legal charges. She manages her own finances. She schedules and attends medical appointments and reports taking medications as prescribed. She has worked to build stronger relationships with her family and has some supportive people in her life. She is making progress toward her GED and has a goal of attending [redacted]. It appears the majority of assistance preparing for the GED occurs at [redacted] (not a [redacted] program.)
>
> (Exhibit 1, page 15)

The CMH also noted that the Appellant may choose to continue individual therapy by utilizing her Medicare coverage and may choose to access community supports through the [redacted] and her continued participation at [redacted] (Exhibit 1, page 15) Accordingly, the CMH sent an Appeal Disposition to Appellant stating the determination to terminate the individual therapy and [redacted] services was upheld because medical necessity for the services was not met. The notice stated that in reviewing the Appellant's records, it was evident that progress was made toward the goals and objectives in the Appellant's Plan of Service and with the gains she has made, the Appellant demonstrated she no longer requires specialty-level community mental health services. (Exhibit 1, pages 3-4)

The Appellant disagrees with the termination and testified she has serious health issues. The Appellant can barely walk and has COPD. The Appellant also stated she cannot just run to all these places on a bus. One of the places recommended requires walking up three stories, which the Appellant cannot do. That place also does not have structured programing. The Appellant knows what goes on at [redacted], knows the people there and is comfortable there. The Appellant is not comfortable with new things. Regarding family support, the Appellant only has contact with an [redacted]-year-old aunt, who can barely get around anymore. While the Appellant found her granddaughters last year, they live in [redacted] and she only talks to them maybe once every [redacted] months. However, the Appellant confirmed that she just got new insurance through her Medicare and they are paying for the individual therapy services. The Appellant stated she only needs the [redacted] services at [redacted] now. (Appellant Testimony)

The Appellant also submitted documentation from her therapist and a letter from the [redacted]. (Exhibits 2-4) The [redacted] letter of support for continuing services at [redacted]s from the therapist indicates the Appellant has benefited from these services but also documents that she had made progress in some areas. (Exhibit 4, page 1)

The Appellant bears the burden of proving by a preponderance of the evidence that the CMH determination to terminate the individual therapy and [redacted] services was incorrect. Here, the Appellant did not prove by a preponderance of the evidence that the medical necessity criteria were met to allow for ongoing services. Rather, the evidence consistently indicates that the Appellant has made progress toward her goals and improvements in her functioning. The Appellant is also participating in other community supports such as preparing for her GED by attending classes/programing at [redacted] Further, the Appellant's individual therapy services are now being covered through Medicare. Accordingly, the CMH's determination to terminate individual therapy and [redacted] services for the Appellant must be upheld.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

***** 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.