STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 14-011994 CMH

[redacted] [redacted] [redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on his own behalf. [redacted], Fair Hearings Officer, represented Respondent [redacted] Community Mental Health (CMH). [redacted] Case Manager, testified as a witness for the CMH.

ISSUE

Did the CMH properly close Appellant's case?

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

2. Appellant is a [redacted] year-old male who has been diagnosed with major depressive disorder, recurrent, severe without psychotic features; alcohol dependence; and personality disorder, not otherwise specified. (Respondent's Exhibit A, page 5).

3. Appellant applied for services with the CMH and an initial assessment was conducted on [redacted] (Respondent's Exhibit A, pages 1-5).

4. Subsequently, he was approved for services and an Individual Plan of Service (IPOS) meeting was held on [redacted]. (Respondent's Exhibit B, pages 1-5).

5. In that IPOS, Appellant was approved for several services, including a psychiatric evaluation, medication reviews, registered nurse services, peer services, and targeted case management. (Respondent's Exhibit B, pages 1-5).

6. On [redacted], Appellant's services were terminated at his request. (Respondent's Exhibit G, page 1; Respondent's Exhibit H, page 1; Testimony of Appellant; Testimony of Weiss).

7. On March 20, 2014, Appellant telephoned the CMH and requested that his case be reopened, which the CMH agreed to do. (Respondent's Exhibit J, page 1; Respondent's Exhibit K, page 1; Testimony of Appellant; Testimony of [redacted].

8. Subsequently, several attempts were made to meet with Appellant and conduct an annual assessment required by policy. (Respondent's Exhibit L, pages 1-3; Respondent's Exhibit M, pages 1-8; Respondent's Exhibit N, page 1; Respondent's Exhibit O, page 1; Respondent's Exhibit P, page 1; Respondent's Exhibit Q, page 1; Respondent's Exhibit R, page 1; Testimony of Appellant; Testimony of [redacted].

9. However, Appellant always failed to appear for scheduled appointments, often without telephoning the CMH to let them know or reschedule, and his former IPOS expired on [redacted]. (Respondent's Exhibit L, pages 1-3; Respondent's Exhibit M, pages 1-8; Respondent's Exhibit N, page 1; Respondent's Exhibit O, page 1; Respondent's Exhibit P, page 1; Respondent's Exhibit Q, page 1; Respondent's Exhibit R, page 1; Testimony of Appellant; Testimony of [redacted]

10. On [redacted] the CMH sent Appellant written notice that his case would be closed effective [redacted], because he had no active prescriptions or services, he was doing better, and he had failed to make his scheduled appointments. (Respondent's Exhibit T, page 1; Testimony of [redacted]).

11. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing. (Petitioner's Exhibit 1, page 1).

12. On [redacted], Appellant and the CMH scheduled another meeting for [redacted], but Appellant again failed to appear for that meeting or call in to the CMH. (Respondent's Exhibit U, page 1; Respondent's Exhibit V, page 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

Additionally,

> 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 also 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 USC 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.

Here, the CMH contracts with the MDCH to provide services pursuant to its contract obligations with the Department, but eligibility for those services is still set by Department policy.

With respect to eligibility, the applicable version of the Medicaid Provider Manual (MPM) states in part that Medicaid mental health services must be both medically necessary and periodically reassessed:

> **SECTION 2 – PROGRAM REQUIREMENTS**
>
> **2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES**
>
> Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:
>
> - Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
>
> - Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
>
> - Coordinated with other community agencies (including, but not limited to, Medicaid Health

Plans [MHPs], family courts, local health departments [LHDs], MIChoice waiver providers, school-based services providers, and the county Department of Human Services [DHS] offices).

- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually

approved and monitored by a behavior treatment plan review committee.

* * *

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;

- that are 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.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 8, 12-14

The CMH closed Appellant's pursuant to the above policies. Specifically, its witness testified that the case closure was based on the fact that, due to Appellant's repeated failure to make appointments, it had been unable to complete the required annual assessment or determine if services were still medically necessary given that Appellant's services were previously terminated at his own request, he had been without services for months, and his IPOS had expired. Moreover, while the CMH was willing to reopen the case, it was ultimately unable to do so or develop a new IPOS because of Appellant's inaction.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in closing his case.

Here, Appellant does not dispute the CMH's evidence and findings, and he acknowledged that he has repeatedly failed to make appointments or call in to the CMH

to reschedule. Instead, he only apologized for consistently missing appointments and asks for another chance to receive services.

To the extent Appellant wishes to reapply for services, he is always free to do so. However, the past case closure at issue in this case must still be affirmed given the undisputed record and the applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly closed Appellant's case.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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.