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. 14-007958 CMH
Case No.

Appellant
______________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Appellant's request for a hearing.

After due notice, a hearing was held . Appellant appeared on her own behalf.

, Assistant Corporation Counsel, Community Mental Health Authority (CMH), represented the Department. , Director, appeared as a witness for the Department.

ISSUE

Did the CMH properly determine that Appellant did not meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH as someone 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. Appellant is a year-old Medicaid beneficiary, born , who requested services through CMH in . (Exhibit A, p 10; Testimony)

2. Appellant is diagnosed with major depressive disorder, recurrent, severe with psychosis. Appellant's symptoms include sad affect, anxiety, low motivation, irritability, paranoia and auditory hallucinations. (Exhibit A, p 18; Testimony)

3. Appellant is prescribed the medications Effexor, Risperdal, Elavil, and Cogentin, as well as a medication for high cholesterol. (Testimony)

4. Appellant lives alone in her own home. Appellant handles her own finances and is able to drive. Appellant is not working and receives Social Security Disability. Appellant was hospitalized in [redacted] for her mental health issues. (Exhibit A, p 10; Testimony)

5. On [redacted], an access screening was conducted to determine if Appellant was eligible for services as a person with a serious mental illness, as defined by the Michigan Mental Health Code. Following the screening, CMH's clinician determined that Appellant was not eligible for CMH services because she did not have a serious mental illness and she would be able to receive the services she needed, specifically outpatient therapy and medications, through her Medicaid Health Plan. (Exhibit A, pp 10-19; Testimony)

6. The Michigan Mental Health Code, Medicaid Provider Manual, and the MDCH/CMHSP Mental Health Supports and Services Contract specify that the CMH is responsible for treating the most severe forms of mental illness and that the Medicaid Health Plans (MHP's) are responsible for treating mild to moderate conditions.

7. On [redacted], CMH sent Appellant a notice indicating that she did not meet eligibility criteria for CMH services as a person with a serious mental illness. The notice informed Appellant of her right to a fair hearing. (Exhibit A, p 5)

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for a hearing. (Exhibit 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
>
> 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—

Under approval from the Center for Medicaid and Medicaid Services (CMS) the Michigan Department of Community Health (MDCH) operates a section 1915(b) waiver called the Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the MDCH to provide services under the Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. CMH must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, amended, and those services/supports included as part of the contract between the Department and CMH.

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 provides:

> 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 <u>mild or moderate psychiatric symptoms</u> 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 services and supports.	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. 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 Section
July 1, 2014, p 3

Case Management services are also defined in the Medicaid Provider Manual:

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. 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.
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 shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

> Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
July 1, 2014, pp 69-70

"Serious mental illness" is defined in the Mental Health Code as follows:

> 330.1100d Definitions; S to W.
> Sec. 100d.
>
> * * * *
>
> (3) "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> (a) A substance abuse disorder.
>
> (b) A developmental disorder.
>
> (c) A "V" code in the diagnostic and statistical manual of mental disorders.
>
> * * * *
>
> MCL 330.1100d(3)

CMH's [REDACTED] Director testified that the [REDACTED] at CMH makes determinations regarding eligibility for services as well as what level of care someone needs if they are found eligible for services. CMH's [REDACTED] [REDACTED] Director indicated that Appellant is a [REDACTED] year-old Medicaid beneficiary diagnosed with major depressive disorder,

recurrent, severe with psychosis. CMH's Director indicated that Appellant lives alone in her own home, handles her own finances, is able to drive, and receives Social Security Disability. The CMH's Director testified that the Michigan Mental Health Code, Medicaid Provider Manual, and the MDCH/CMHSP Mental Health Supports and Services Contract specify that the CMH is responsible for treating the most severe forms of mental illness and that the Medicaid Health Plans (MHP's) are responsible for treating mild to moderate conditions. Here, CMH's Director testified that following a screening, CMH's clinician determined that Appellant was not eligible for CMH services because she did not have a serious mental illness and she would be able to receive the services she needed, specifically outpatient therapy and medications, through her Medicaid Health Plan. The CMH's Director testified that her review of Appellant's records also showed that Appellant has not had a serious mental illness in the past 12 months and has no substantial limitations in activities of daily living.

Appellant testified that she does receive medications through , but they told her that she cannot continue to get her medications unless she sees a psychiatrist, hence her attempt to obtain services through CMH. Appellant indicated that she was also seeing a case worker at , but only saw her 2-3 times. Appellant testified that she has been in psychiatric hospitals in the past and did attempt suicide in . Appellant indicated that it took her doctor a long time to get her medications situated and she will be very ill if she does not get her medications. Appellant indicated that no-one ever told her she was eligible for a Medicaid Health Plan and, to her knowledge; she has never enrolled in such a plan. Appellant testified that she has used alcohol and drugs in the past to control her symptoms and that she still has paranoia and hallucinations.

In response, CMH's Director testified that if Appellant enrolled in a MHP, she would be able to see a psychiatrist to control and prescribe her medications. CMH's Director testified that CMH could assist Appellant with enrolling in a MHP.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid covered mental health services and properly determined that she is not because she is currently not a person with a serious mental illness. Following an eligibility assessment, CMH determined that Appellant's symptoms were mild to moderate. As indicated above, the Medicaid Provider Manual provides that the CMH is responsible for treating the most severe forms of mental illness and that the Medicaid Health Plans are responsible for treating mild to moderate conditions. Here, Appellant is eligible for a Medicaid Health Plan and can receive the services she needs through that plan. Appellant is able to live alone, handle her own finances, and drive a car. And while Appellant has been hospitalized for her mental illness in the past, the last hospitalization was in . Should Appellant's condition worsen, she is free to request another assessment. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH.

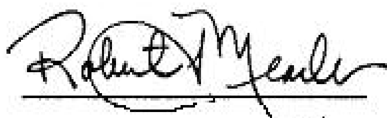
DECISION AND ORDER

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

The CMH properly determined that Appellant does not meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.



Robert J. Meade
Administrative Law Judge
for Nick Lyons, Acting Director
Michigan Department of Community Health

cc:

RJM/

Date Signed: __

Date Mailed: __

*** **NOTICE** ***

The Michigan Administrative Hearing System for the Department of Community Health 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.