

**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:

████████████████████

Appellant

\_\_\_\_\_ /

Docket No. 2014-35770 CMH

Case No. ██████████

**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 his behalf. ██████████, Agency Corporate Compliance and Privacy Officer, appeared on behalf of ██████████ (CMH or the Department). ██████████, Utilization Care Coordinator, 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 May 2013. (Exhibit A, p 1; Testimony)
2. Appellant is diagnosed with major depressive disorder, recurrent, unspecified and cannabis dependence, episodic use. (Exhibit A, p 7; Testimony)
3. Appellant is prescribed the medications Baclofen, Diclofenac, Gabapentin, and Topiramate. (Testimony)
4. Appellant lives with his mother or with other friends and family in the community. (Testimony)

**Docket No. 2014-35770 CMH**  
**Decision & Order**

5. On [REDACTED] 14, 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 he did not have a serious mental illness and he would be able to receive the services he needed, specifically outpatient therapy and medications, through his Healthy Michigan Plan, Health Plus Partners. (Exhibit A, pp 1-14)
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 he did not meet eligibility criteria for CMH services as a person with a serious mental illness. The notice informed Appellant of his right to a fair hearing. (Exhibit A, p 15-16)
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

**Docket No. 2014-35770 CMH**  
**Decision & Order**

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

**Docket No. 2014-35770 CMH**  
**Decision & Order**

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:**

- 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.) 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.

**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**

- 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.,

**Docket No. 2014-35770 CMH**  
**Decision & Order**

|  |  |
|--|--|
|  | improvement in the beneficiary's condition) of the additional treatment. |
|--|--|

*Medicaid Provider Manual*  
*Mental Health and Substance Abuse Section*  
*April 1, 2014, p 3*

“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)

The CMH’s Utilization Care Coordinator testified that prior to requesting services through CMH, Appellant had been receiving services through the Adult Benefit Waiver, which ended [REDACTED]. The CMH’s Utilization Care Coordinator indicated that the Adult Benefit Waiver treated persons on an outpatient level and did not treat patients with serious mental illness. The CMH’s Utilization Care Coordinator indicated that she reviewed Appellant’s records and determined that Appellant had no history of receiving any acute mental health services and had very little history of any linking and coordination

**Docket No. 2014-35770 CMH**  
**Decision & Order**

of services. The CMH's Utilization Care Coordinator testified that Appellant's symptoms were not severe, that there was no history of suicidal or homicidal behaviors, and no history of inpatient hospitalizations for mental health issues. The CMH's Utilization Care Coordinator testified that based on the documentation reviewed, Appellant did not meet the mental health code definition of a person with a serious mental illness. The CMH's Utilization Care Coordinator testified that Appellant's needs for outpatient therapy and medications were covered by his Medicaid Health Plan.

Appellant testified he is currently receiving outpatient therapy and medications through his Medicaid Health Plan. Appellant indicates that he goes to therapy about 3 times per month and will be seeing a new therapist this month because his old therapist left. Appellant indicated that he lives with his mother and sometimes with other family and friends. Appellant testified that he was looking for a case manager to help him with housing, applying for disability, or finding a job. Appellant indicated that he had never been hospitalized for psychiatric services and is currently receiving no services besides medications and outpatient therapy through his MHP. Appellant testified that he was just trying to get all of the help that he can. Appellant also indicated that he was seeing a physical therapist for his leg pain.

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 he is not because he is not a person with a serious mental illness. Following an eligibility assessment, CMH determined that Appellant lacked a qualifying diagnosis of severe mental illness and 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 has a Medicaid Health Plan and can receive the services he needs through that plan. In fact, Appellant is currently receiving those services through his MHP. Should Appellant's condition worsen, he is free to request another assessment. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH.

[REDACTED]  
Docket No. 2014-35770 CMH  
Decision & Order

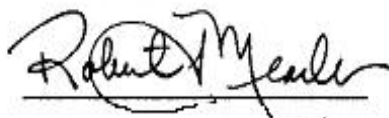
**DECISION AND ORDER**

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 James K. Haveman, Director  
Michigan Department of Community Health

cc:

[REDACTED]

RJM [REDACTED]

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

**\*\*\* 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.

