STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
Phone: (877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 14-015121 CMH
Case No. [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]. Appellant is a minor child, DOB [redacted]. Appellant's mother, [redacted], appeared on behalf of Appellant. [redacted], Utilization Manager appeared and testified on behalf of Respondent, [redacted] (Respondent or CMH).

ISSUE

Whether Appellant was at all times relevant a Medical Assistance (MA) benefit?

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 minor child who has Autism and Speech Apraxia.

2. Appellant is a Medicaid benefit recipient who had a monthly deductible spend-down.

3. On [redacted] [redacted] received notification from Michigan Department of Community Health (MDCH) of reduction of General Funds

4. On [redacted] the MDCH conducted a utilization review of all consumers utilizing General Funds to cover services, including Appellant.

5. [redacted] non-Medicaid notice was sent to Appellant to be effective [redacted]

6. On [redacted] Appellant filed an appeal to contest the negative action. Services continued pending the outcome of the hearing.

7. On [redacted] [redacted] determined that the Michigan Department of Human Services had updated Medicaid eligibility. Appellant's deductibles were met [redacted].

8. [redacted] determined that [redacted] to present, Appellant had not met his deductible.

9. At the commencement of the hearing, Respondent raised the issue that jurisdiction for a fair hearing was lacking in this matter because Appellant was not a Medicaid beneficiary. Attachment D to Exhibit A is a printout of a Medicaid eligibility summary for Appellant. The summary shows that at the time the action in this matter was taken, [redacted], Appellant had not met his deductible and was not eligible for Medicaid.

10. The Department of Human Services' delay in updating Appellant's Medicaid eligibility caused it to appear that Appellant had not met his deductible spend-down at the time of the negative action notice.

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.

The Code of Federal Regulations (CFR) affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *42 CFR 438.400.*

> 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) Medicaid Managed Specialty Services waiver. [redacted] CMH contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

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; 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.

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

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

MPM, Mental Health and Substance Abuse Section, October 1, 2013, pp 12-13

It is the contention of [redacted] that Appellant is not a current Medicaid customer and the deductible spend-down was not met. Therefore, he falls into the category of a general fund customer and the MDCH/CMHSP Managers Mental Health Supports and Services Contract Y15, the level and scope of such services are contingent on the available funding, and services provided through the use of general funds are not an entitlement to any individual recipient. As well, Appellant is covered under private health insurance [redacted] coverage for the services. In either case, with Medicaid as the payer of last resort and the expectation that providers must utilize other payment sources to the fullest extent prior to filing a claim with MDCH, Appellant has

access to services and community by [redacted] and receives services through the school, (States Exhibit 2).

Appellant's representative contends that appellant was at all times relevant to this case a Medicaid benefit recipient and that appellant had met the deductible spend down at all times relevant to this case. Also, the Department of Human Services had not confirmed that Appellant had met deductible spend down because the Department of Human Services was behind in its record-keeping process. Moreover, there are no other services in the Community which address the Appellant's needs for the services provided by [redacted].

In the instant case, Appellant has Medicaid, but DHS had not confirmed that Appellant met his deductible spend-down at the time of the negative action. However, as of [redacted] [redacted] conceded on the record that DHS had updated Medicaid eligibility records and that deductibles for Appellant were met [redacted] through [redacted]. As such, Appellant was a Medicaid beneficiary who was denied a Medicaid covered service.

The burden is on Appellant to prove by a preponderance of evidence that he was a Medicaid beneficiary at all times relevant to this case even though DHS had not confirmed eligibility on [redacted], when [redacted] sent claimant notice of cancellation of the use of general funds to cover services. As indicated above, Appellant did meet this burden. Appellant has established that he was at all times relevant to this hearing, a Medicaid beneficiary who was denied a Medicaid covered service. [redacted]' determination to cancel services based upon the reason given in the Notice of Case Action cannot be upheld under the circumstances.

DECISION AND ORDER

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

> Appellant was at all times relevant to this hearing eligible for covered Medicaid Services. The CMH improperly denied authorization for continued case management services for Appellant.

IT IS THEREFORE ORDERED that:

The CMH's decision is REVERSED. The CMH is ODERED to re-evaluate Appellant's eligibility for continued services through [redacted] in accordance with Department policy and if Appellant is otherwise eligible, reinstate appropriate services to Appellant.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

LYL[redacted]

Date Signed: [redacted]

Date Mailed: [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.