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:

[redacted] Docket No. [redacted] 15-000498 CMH

Appellant
_____/

DECISION AND ORDER

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

After due notice, a telephone hearing was held [redacted]. [redacted] Appellant's aunt appeared and testified on the Appellant's behalf. Appellant was present for the hearing but did not testify.

[redacted] (CMH) Customer Services Specialist, appeared on behalf of the Department. [redacted] LLMSW, Clinician/Therapist with [redacted] and [redacted], LMSW, [redacted]t Clinical Director testified on behalf of the Department.

ISSUE

Did CMH act properly in terminating Appellant's Medicaid Specialty Supports and Services because Appellant no longer qualified for services through CMH?

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 (DOB: [redacted]) Medicaid beneficiary. (Exhibit A, p.1 and testimony).

2. CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.

3. CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.

4. On [redacted], Appellant began receiving CMH services as an adult with a serious mental illness. Appellant was diagnosed with Major

Depressive Disorder, Single Episode, Severe with Psychotic Features. (Exhibit B, pp. 2, 3, 8; Exhibit D, pp. 3, 5, 7-15, 17; Exhibit G, p. 13 and testimony).

5. On [redacted], CMH sent Appellant a letter regarding her missed appointments during the past month stating that her case would be closed if she did not contact them within seven days. (Exhibit B, p. 6 and testimony).

6. On N[redacted]r [redacted] LLMSW, met with Appellant and did an assessment of her current need for services through CMH. [redacted] determined that the Appellant was no longer eligible for mental health services through CMH as her symptoms had improved to the point that she no longer was diagnosed with a serious mental illness, and she was given the options of outpatient services or closing out her services and having her medications transferred to her primary care physician (PCP). Appellant chose to close out her CMH services and have her medications transferred to the PCP. (Exhibit D, pp. 3-4 and testimony).

7. On [redacted], [redacted] again met with Appellant who stated she had changed her mind about discontinuing services through CMH. [redacted] advised she would refer the matter to her supervisor who would refer the matter to outpatient treatment services for an eligibility determination. (Exhibit D, pp. 5-6 and testimony).

8. On [redacted] called the Appellant to advise her that she was no longer eligible for CMH outpatient therapy, and discussed a possible referral to a local agency/therapist who would take her insurance. (Exhibit D, p. 7 and testimony).

9. On [redacted] was advised by Appellant's PCP that they made a referral for Appellant to [redacted], and she contacted the Appellant to advise her of the referral and her upcoming appointment date and time at [redacted]. (Exhibit D, p. 9 and testimony).

10. On [redacted] CMH sent Appellant an Adequate Action notice dated [redacted], advising her she no longer qualified for services through CMH, and that her services were being closed with CMH and transferred to [redacted]. (Exhibit D, pp. 1, 16-18 and testimony).

11. On [redacted], MAHS received the Appellant's request for an Administrative Hearing. (Exhibit E, p. 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 proofs presented by CMH demonstrated that on [redacted] the Appellant began receiving services through CMH as an adult with a serious mental illness. [redacted], LLMSW was assigned as Appellant's Clinician/Therapist. Appellant was diagnosed with Major Depressive Disorder, Single Episode - Severe with Psychotic Features. After a psychiatric evaluation, Appellant was placed at [redacted] because her psychiatrist found she would to be unsafe if released to go home or into the community. Thereafter, she was sent for hospitalization at [redacted] an inpatient psychiatric hospital. Appellant was hospitalized for about [redacted] days and after she was discharged [redacted] continued to meet with the Appellant.

[redacted] stated there was marked change in the Appellant upon her release from [redacted]. Appellant's affect was different and her mood was positive. Appellant reported to [redacted] that she had a very positive experience while at [redacted]. Appellant was then scheduled for an aftercare appointment with her psychiatrist on [redacted] which ended up being rescheduled three separate times, but it never took place. [redacted] stated at that point Appellant's participation in treatment became inconsistent. [redacted] stated that between [redacted] and [redacted] she made several attempts to meet with the Appellant without success. On [redacted], [redacted] sent Appellant a letter regarding her missed appointments during the past month stating that her case would be closed if Appellant did not contact her within seven days.

[redacted] stated she next met with the Appellant on [redacted] and did an assessment of her current need for services through CMH. [redacted] determined that the Appellant was no longer eligible for mental health services through CMH as her symptoms had improved to the point that she no longer had a serious mental illness. [redacted] stated she gave the Appellant the options of a referral for outpatient services or having CMH close out her services and having her medications transferred to her primary care physician (PCP). Appellant chose to close out her CMH services and have her medications transferred to the PCP.

[redacted] stated that on [redacted] she again met with Appellant who stated she had changed her mind about discontinuing services through CMH. [redacted] advised the Appellant that she would refer the matter to her supervisor who would refer the matter to outpatient treatment services for an eligibility determination. [redacted] stated that on [redacted], she called the Appellant to advise her that she was no longer eligible for CMH outpatient therapy, and she discussed a possible referral to a local agency/therapist who would take the Appellant's insurance.

On [redacted] was advised by Appellant's PCP that they made a referral for Appellant to [redacted], and she contacted the Appellant to advise her of the referral and her upcoming appointment date and time at [redacted]. [redacted] stated that on [redacted], she sent Appellant an Adequate Action notice dated [redacted], advising her she no longer qualified for services through CMH, and that her services were being closed with CMH and transferred to [redacted]

[redacted] stated the Appellant was enrolled in a Medicaid Health Plan that would cover her outpatient therapy services.

[redacted], LMSW, [redacted] Clinical Director stated while the Appellant had a diagnosis of Major Depressive Disorder, Single Episode, Severe with Psychotic Features, her level of impairment and functioning had improved and no longer qualified her for CMH services as an adult with a serious mental illness. [redacted] stated the Appellant's condition could be treated at a lower level of care. Accordingly, it was appropriate to refer Appellant out to [redacted] for some individual therapy that would be covered by her Medicaid Health Plan.

The section of the Medicaid Provider Manual quoted below governs whether a person is eligible for Mental Health services through CMH or if the services must be obtained through their Medicaid Health Plan (MHP). The decision is based on the severity of the individual's psychiatric signs, symptoms, and the extent of their functional impairment. The Department's witnesses found that the Appellant was not seriously mentally ill and did not have any clinically significant impairment that would require specialized services. The Department's witnesses found that the Appellant could continue to obtain her individual therapy sessions through a referral from her PCP that would be covered by her insurance.

This Administrative Law Judge does not have jurisdiction to order the CMH to provide Medicaid covered services to a beneficiary who is not eligible for those services. This Administrative Law Judge determines that the Appellant is not eligible for CMH Medicaid covered services for the reasons discussed below.

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 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 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 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 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, §1.6 Beneficiary Eligibility Section,* October 1, 2014, p. 3].

The CMH must follow the Department's Medicaid Provider Manual when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria,* Section 2.5, October 1, 2014 lists the criteria the CMH must apply as follows:

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. [pp. 12-14].

Appellant's aunt testified the Appellant is a young lady who deals with a lot of mental issues. She said the Appellant is not always the best decision maker regarding her own care. Her aunt said she did not think the Appellant was capable of making her own care decisions [redacted] to [redacted] percent of the time. Appellant's aunt said the Appellant fell back after she was sent for inpatient treatment and lost her trust in [redacted]. She claimed the Appellant did not comprehend anything [redacted] was saying during their meetings regarding her care. She said the Appellant was deciding on her own not to make her appointments with [redacted] due to a lack of trust. Appellant's aunt acknowledged that the Appellant's score on the LOCUS assessment was a good score, but thinks the Appellant made up the information to get a good assessment so she wouldn't get sent back to the psychiatric hospital. She said she did not think it was a good fit with [redacted] and would like someone else at CMH to work with the Appellant. She also claimed that [redacted] referred her back to CMH due to her condition, but CMH stated that there was no referral from Mercy for the Appellant.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant continued to be eligible for Medicaid Covered mental health services and properly determined she was not. The information available to the CMH at the time it determined she was not eligible for services showed she did not meet the eligibility criteria as an adult with a serious mental illness.

The testimony of the Appellant's aunt does not change the previous decision of CMH. Appellant did not establish that she has a serious mental illness which would qualify her for services through CMH. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH. Rather, the Appellant may receive the services she needs through a referral by her PCP to a local agency/therapist covered by her Medicaid Health Plan.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH acted properly in terminating Appellant's Medicaid Specialty Supports and Services because Appellant no longer qualified for services through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

cc: [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.