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

IN THE MATTER OF:

[redacted]

Docket No. 15-018310 CMH
Case No. [redacted]

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 on [redacted]. Appellant appeared on her own behalf.

[redacted], Manager, Due Process, appeared on behalf of [redacted] (CMH or Department). [redacted], Interim Director, Access Center and Utilization Management and [redacted], Care Coordinator, Utilization Management, appeared as witnesses for the Department.

ISSUE

Does the Appellant meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH as someone with a developmental disability or 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 [redacted] year-old Medicaid beneficiary, born [redacted], who was diagnosed in [redacted] with bi-polar disorder in partial remission and no specifiers. Appellant also has a history of substance abuse, including opioids, crack cocaine and cannabis. (Exhibit A, pp 1, 37; Testimony)

2. Appellant lives with her boyfriend and her boyfriend's mother, who are also her natural supports. (Exhibit A, p 3; Testimony)

3. Appellant is eligible for straight fee-for-service Medicaid and is also eligible for Medicare. (Exhibit A, pp 42-44; Testimony)

4. On [redacted], CMH's Utilization Management Department completed an eligibility audit. Based on the documentation in Appellant's electronic medical record, including assessments, progress notes, and evaluations, it was determined that Appellant no longer met the eligibility criteria as a person with a serious mental illness or a developmental disability. The reviewer found that Appellant had not consistently taken psychotropic medication and had had no medications prescribed since [redacted]. Progress notes showed that Appellant was without mood and thoughts disorders except during times when she was actively using drugs and that Appellant had been without any complaints when she was sober. The review found that Appellant had been in treatment for substance abuse but relapsed in [redacted]. (Exhibit A, pp 36-38; Testimony)

5. 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 are responsible for treating mild to moderate conditions. (Exhibit A; Testimony)

6. On [redacted], CMH sent Appellant an Advance Action Notice informing her that her services would be terminated effective [redacted] because: "You do not meet medical necessity for specialty services. Please see your case manager to complete your transition to outpatient mental health services and substance abuse treatment." The notice informed Appellant of her right to a Medicaid fair hearing. (Exhibit A, pp 39-41; Testimony)

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for an Administrative 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 Health and Human Services (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 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.	□ 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
October 1, 2015, 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)

Developmental disability is defined in the Mental Health Code as follows:

(21) “Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

(i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
(ii) Is manifested before the individual is 22 years old.
(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

MCL 330.1100a

CMH’s Care Coordinator testified that she has a PhD in psychology and is a Licensed Masters Social Worker (LMSW). CMH’s Care Coordinator indicated that she completed the utilization review that led to the termination of Appellant’s services. CMH’s Care Coordinator testified that in conducting the utilization review, she reviewed Appellant’s entire electronic medical record, including her Individual Plan of Service (IPOS), Contact and Progress Notes, Psychological Evaluations and Medication Reviews. CMH’s Care Coordinator testified that following the review she determined that Appellant no longer met the eligibility criteria as a person with a serious mental illness or a developmental disability. CMH’s Care Coordinator found that Appellant had not consistently taken psychotropic medication and had had no medications prescribed since [redacted]. CMH’s Care Coordinator testified that progress notes showed that Appellant was without mood and

thoughts disorders except during times when she was actively using drugs and that Appellant had been without any complaints when she was sober. CMH's Care Coordinator found that Appellant had been in treatment for substance abuse but relapsed in [redacted]. CMH's Care Coordinator testified that Appellant is eligible for Medicaid and can receive the services she needs, including medications, therapy, and substance abuse treatment through Medicaid. CMH's Care Coordinator testified that in her professional opinion, Appellant did not meet the definition of a person with a serious mental illness or developmental disability and, as such, was no longer eligible to receive services through CMH.

Appellant testified that she was off her medications since [redacted], but was recently put back on the medications since this termination occurred. Appellant indicated that she takes Topamax, Lamictal, Buspar and Neurontin currently. Appellant testified that her condition is getting worse. Appellant indicated that she did miss several appointments in the past due to transportation issues and her boyfriend's mother being in the hospital. Appellant testified that her case manager had told her it was up to her if she wanted to be on medications and that her case manager told her "good for you" when she went off the medications. Appellant indicated that she has straight Medicaid as well as Medicare. Appellant testified that she would like to continue her services through CMH.

In this case, CMH applied the proper eligibility criteria to determine whether Appellant was eligible for continued Medicaid covered mental health services and properly determined she is not because she is not a person with a developmental disability or serious mental illness. Following a utilization management review, CMH determined that Appellant's symptoms were mild to moderate, except when she was using drugs. 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 straight Medicaid and can receive the services she needs, including her medications, therapy, and substance abuse treatment, through that plan. 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 the 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 Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

RJM/cg

Date Signed: [redacted]

Date Mailed: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Health and Human Services 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.