STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted] **Docket No.** 15-011223 CMH [redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] represented Respondent [redacted] Community Mental Health (CMH). [redacted] Medical Director, and [redacted], Director of Integrated and Managed Health Services, testified as witnesses for the CMH.

ISSUE

Did the CMH properly terminate Appellant's psychiatric services?

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 who has been diagnosed with Borderline Personality Disorder. (Testimony of [redacted]).

2. Appellant had been authorized for psychiatric services through the CMH and was treated by a psychiatrist until [redacted] (Testimony of [redacted]).

3. The services with the psychiatrist ended when the psychiatrist retired. (Testimony of Appellant).

4. Appellant has not received any psychiatric services since that time, but her case has remained open and she would see a nurse who coordinates care with psychiatrists and the nurse would act like a case manager for Appellant. (Testimony of Appellant; Testimony of [redacted].

5. [redacted] was assigned to Petitioner's case in [redacted] and, as part of her review, she discovered that Appellant had not utilized any psychiatric services since [redacted]. (Testimony of V[redacted].

6. Vincent also noted that Appellant had been offered individual and group therapy, but that she had declined the services. (Testimony of [redacted]).

7. According to Appellant, she declined therapy because she had tried it before and it was not helpful. (Testimony of Appellant).

8. On [redacted] the CMH sent Appellant written notice that her psychiatric services would be closed effective [redacted] because she had not seen a psychiatrist in two years and had been offered therapy. (Exhibit 1, page 2; Exhibit A, page 1).

9. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that termination. (Exhibit 1, pages 1-2).

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 statutes, 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*

Additionally, 42 CFR 430.10 states:

> 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 also 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…

42 USC 1396n(b)

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 Health and Human Services (DHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Services that may be provided through that waiver by the CMH are set forth in the Department policy outlined in the Medicaid Provider Manual (MPM) and they can include assessments; individual/group therapy; medication administration; medication reviews; and targeted case management. *See* MPM, April 1, 2015 version, Mental Health/Substance Abuse Chapter, pages i-ii.

Moreover, regarding the general staff provider qualifications, the MPM provides in part that:

> **2.4 STAFF PROVIDER QUALIFICATIONS**
>
> Providers of specialty services and supports (including state plan, HSW, and additional/B3) are chosen by the beneficiary and others assisting him/her during the person-centered planning process, and must meet the staffing qualifications contained in program sections in this chapter. In addition,

> qualifications are noted below for provider staff mentioned throughout this chapter, including the Children's Waiver. The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Credentialing and re-credentialing standards located in the Quality Assessment and Performance Improvement Program in the MDCH/PIHP contract must be followed. Michigan laws regarding licensing and registration of professionals are found in the Public Health Code, the Mental Health Code and the Michigan Administrative Rules. These regulations define the scope of practice for each professional as well as requirements for supervision.
>
> *MPM, April 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, page 11*

However, Medicaid beneficiaries are still only entitled to medically necessary services as the waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM states:

> **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;

- 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;
  - that are 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, April 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 12-14

Here, pursuant to the above policies, the CMH terminated Appellant's services with a psychiatrist on the basis that the services were not medically necessary. In support of that decision, [redacted] testified that Appellant has no need for a psychiatrist as the treatment of choice for her diagnosis is psychotherapy and Appellant has been offered

such therapy by the CMH. He also testified that medications would be of limited efficacy for Appellant; prescribing them is not based on evidence; and that, to the extent they are even appropriate, Appellant's primary care physician could prescribe them and seek consultations with psychiatrists or others as necessary. [redacted] further testified that Appellant has not seen a psychiatrist for two years, but has remained stable with only mild or moderate symptoms during that time. She also noted that Appellant has been offered therapy in the past and declined it, but that the CMH would offer therapy again.

In response, Appellant testified that her treatment with the psychiatrist only stopped because the psychiatrist retired and that Appellant has been trying to see a new one since her psychiatrist retired. She also testified that the pursuit of the new psychiatrist became less of a concern because of the nurse who was helping her, who was like a case manager for Appellant, and because Appellant got admitted to a health clinic where a doctor can prescribe her medications. However, Appellant also testified that she was told that the new doctor can only continue her previously prescribed medications and cannot change them or prescribe new medications as needed; and she argues that she therefore still needs the services of the psychiatrist in order to have one-on-one time with the professional best qualified to address her medications. Appellant further testified that she has been to group therapy twice and she briefly attended individual therapy, but she stopped both because they could not provide her with the help she needed.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in terminating her psychiatric services.

Here, while Appellant asserts that seeing a psychiatrist is medical necessary, she had not seen one for almost two years by the time of the termination and yet she had remained stable during that time. Moreover, while Appellant also asserts that a psychiatrist is necessary as only a psychiatrist can prescribe and manage her medications, [redacted] credibly testified as to how Appellant's medications, to the extent they are even necessary, can be managed by her primary care physician and any necessary consulting physicians. Similarly, Appellant's claim that the doctor who is currently managing her medication cannot change them or prescribe new medications as needed is unsupported by any evidence and is contradicted by the credible testimony of [redacted]. Accordingly, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the CMH erred in terminating her psychiatric services and that the Respondent's decision must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly terminated Appellant's psychiatric services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [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.