STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 15-018362 CMH
Agency Case No.

,

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 . , Appellant, appeared on her own behalf. , husband, appears as a witness for Appellant. , Manager of Due Process, represented the Respondent Health System (GHS or Department). , Registered Nurse Utilization Management, appeared as a witness for GHS.

ISSUE

Did the GHS properly terminate Appellant's 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 year-old Medicaid beneficiary who has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder with Agoraphobia, Mood Disorder, and Cannabis Dependence. (Department Exhibit A, p. 3)

2. Appellant had been authorized for services through GHS. In her most recent Individual Plan of Service (IPOS), for the time period of , through , her authorized services were only supports coordination. (Department Exhibit A, pp. 1-7)

3. On , the GHS Utilization Management Department completed an eligibility audit. It was determined that Appellant no longer met the criteria for a person with a serious mental illness or with a developmental disability. (Department Exhibit A, pp. 8-10)

4. On [redacted], GHS sent Appellant written notice that her supports coordination services would be terminated effective [redacted], because she no longer met medical necessity for a consumer that is severely mentally ill and in need of supports coordination. It was also noted that Appellant could access supports in her community per her Medicaid Medicare mental health plan for ongoing routine outpatient therapy and medication. (Department Exhibit A, pp. 11-13)

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Appellant Exhibit 1, pp. 1-5)

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.

GHS contracts with DHHS to provide services pursuant to its contract with the Department and eligibility for services through it is set by Department policy, as outlined in the Medicaid Provider Manual (MPM).

Regarding eligibility for mental health services through entities such as GHS, the MPM states in part that:

1.6 BENEFICIARY ELIGIBILITY

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	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

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.	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.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when 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. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

MPM, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 3-4

The State of Michigan's Mental Health Code defines serious mental illness and serious emotional disturbance as follows:

> 2. "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during 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 the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
>
> a. A substance abuse disorder.
> b. A developmental disorder.
> c. "V" codes in the diagnostic and statistical manual of mental disorders.
>
> 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

Additionally, with respect to developmental disabilities, the Mental Health Code also provides:

(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.

b. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

MCL 330.1100a

Pursuant to the above policies and statutes, the GHS terminated Appellant's services in this case. Specifically, the GHS Eligibility Review noted that Appellant: is able to work

in the community; she has a supportive network, husband, family; she is receiving outpatient services and medication management in the community; and was at one point seriously mentally ill but has not received any crisis services or had any severe exacerbations of symptoms in the last 12 months. Accordingly, Appellant no longer met the criteria to receive services as a person with a serious mental illness. (Registered Nurse Utilization Management Testimony, see also Department Exhibit A, pp. 1-47)

In response, Appellant testified that she is having a lot of difficulties and needs help and support. Appellant explained that her depression is getting a little worse due to her home recently catching fire, she is living with her husband's grandmother, she cannot leave the home without her medication, and she still needs someone to go with her to the grocery store or anything else. Appellant confirmed that she is employed part time and has some natural supports. Appellant also confirmed she sees a psychiatrist outside the GHS, takes medications prescribed by the psychiatrist, and has Medicare and Medicaid insurance coverage. Appellant has not been psychiatrically hospitalized in the last 12 months or received crisis services in the last 6-12 months. (Appellant Testimony)

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

For the reasons discussed below, the undersigned Administrative Law Judge finds that Appellant has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed.

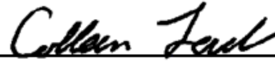
Appellant was previously authorized for services as a person with a serious mental illness. While it is undisputed that Appellant still has a diagnosable mental, behavioral, or emotional disorder affecting her, it does not appear that the diagnosis continues to result in a functional impairment that substantially interferes with or limits Appellant's functioning. The progress notes indicate Appellant was progressing on her ability to get out of her house and get into the community. (Department Exhibit A, pp. 24-46) Appellant continues to be employed, have natural supports, and receive most services outside the GHS. (Registered Nurse Utilization Management and Appellant Testimony) Appellant had only been receiving supports coordination through GHS. (Department Exhibit A, pp. 1-7) It was uncontested that Appellant has not had any psychiatric hospitalizations or received crisis services in the last 12 months. Overall, the evidence does not establish that Appellant continued to meet the eligibility criteria as a person with a serious mental illness. Additionally, there was no evidence to support that Appellant met the eligibility criteria as a person with a developmental disability.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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



Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

CL/

Date Signed: 1/7/2016

Date Mailed: 1/7/2016

cc:

***** 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.