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:

[redacted]

Docket No. 15-021609 CMH
Case No. [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 hearing.

After due notice, a telephone hearing was held on [redacted] Appellant appeared and testified on his own behalf.

[redacted] Manager of Due Process, represented the Respondent [redacted] [redacted] Utilization Management Coordinator, testified as a witness for [redacted].

ISSUE

Did the [redacted] 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 [redacted] Medicaid beneficiary who is enrolled in a Medicaid Health Plan (MHP) [redacted] (Exhibit A).

2. Appellant has also been receiving services through [redacted] including Medicaid covered specialty mental health services, supports of targeted case management, and medication management. (Exhibit A, page 3).

3. The [redacted] Individual Plan of Service Meeting notes state in part that Appellant is making progress, no medication concerns, no hospitalization for psychiatric reasons in over 3 years, told that he no longer meets medical necessity for case management services. (Exhibit A page 9).

4. Progress notes written by Appellant's primary care manager between [redacted] and [redacted] all indicate that Appellant is doing well, stable, is living independently, not experiencing signs or symptoms of serious mental illness (SMI), receives medications from PCP, meeting daily living skills. (Exhibit A, pages 3-84).

5. The [redacted] Quarterly Review of Appellant's services stated that Appellant verbalized medication compliance, denies any and all SI, states he feels medications are working well and presents with good insights into his illness. (Exhibit A, pages 19-27).

6. The [redacted] Quarterly Review of Appellant's services made the same findings. (Exhibit A, pages 28-36).

7. On [redacted] Appellant's case was pulled for an audit. - Pursuant to that review, the report concluded that Appellant no longer meets criteria for specialized services and supports as Appellant no longer meets the definition of SMI on the basis that he lives independently, receive meds from PCP, not experiencing signs or symptoms of SMI, meets daily living skills. (Exhibit A, page 3).

8. On [redacted] sent Appellant written notice that his case management and medication clinic would be terminated effective [redacted] for the following reason:

> You no longer meet medical necessity for a person that is severely mentally ill and needing [redacted] specialty service and supports. Needs can be met in your community provided by your Medicare provider Molina HMO.
>
> *Exhibit A, pages 4-6*

9. On [redacted] the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing filed in this matter.

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.

[redacted]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).

Specifically, the applicable version of the MPM states in the pertinent 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.
>
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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	▪ 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

supports.	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*
> *(Emphasis added by ALJ)*

The State of Michigan's Mental Health Code also defines a serious mental illness as follows:

> 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

Here [redacted] terminated Appellant's services pursuant to the above policies and statutes. In particular, its notice of denial and the testimony of its witness during the hearing provide that, based on the information submitted, Appellant did not meet the above criteria for services because he does not have a serious mental illness, given his stability, lack of negative symptoms and independent living, and because his current mental health needs can be met through his MHP.

In response, Appellant testified he is fearful that if he cannot continue services, that he will be required to see a psychiatrist who will hospitalize him. Appellant also objected to the conclusions on the grounds that the individual who did the audit does not know him personally

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

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed for the reasons set forth below.

The MPM divides coverage responsibilities in this case between [redacted] and Appellant's MHP and, given Appellant' stability and the lack of any severe symptoms, Appellant must seek services through his MHP. At most, the documentation in this case reflects that Appellant may have had severe symptoms in the past and that he is still experiencing some mild or moderate psychiatric symptoms. However, past severe symptoms and current mild symptoms are insufficient to demonstrate that Appellant meets the criteria for continuing services. Moreover, while Appellant and witnesses assert that Appellant has only stabilized because of the services he has been receiving through [redacted] the Respondent can only make its decision based on the information available to it and Appellant's current information demonstrates that he has been stable for over a year and that any of his remaining mental health needs could be met through his MHP.

This ALJ finds that the individual reviewing the record here on behalf of the Respondent had access to all of Appellant's progress notes, made part of the evidentiary record. The Department presented a very thorough review of having taken into account all of Appellant's assessments, a person centered process, without reducing its assessment to a quantitative analysis. Moreover, federal and state law requiring an audit requires that the CMH contain documentation in a beneficiary's file that sufficiently reflects that the categories for which a beneficiary receives Medicaid dollars, such as SMI here, be sufficiently documented. Here, credible and substantial evidence shows that Appellant no longer meets the definition of a SMI.

If Appellant exhausts his services through the MHP or his symptoms significantly worsen and the MHP's services are insufficient; Appellant can always re-request services through [redacted] in the future. With respect to the decision at issue in this case however, [redacted] decision to deny Appellant's request for services must be affirmed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of
Health and Human Services

Date Mailed: [redacted]

JS/cg

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.