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

Docket No. 15-023216 CMH
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted], Case Manager, appeared as a witness for Appellant.

Attorney [redacted], Corporate Counsel for [redacted] (CMH or Department), represented the Department. [redacted], Behavioral Health Specialist and [redacted], Customer Service Manager, appeared as witnesses for the Department.

ISSUE

Did CMH properly terminate Appellant's CLS 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, born [redacted], who has been receiving the following services through CMH: Medication Reviews, Targeted Case Management, and Community Living Supports (CLS). (Exhibit A, p 17; Testimony)

2. Appellant is diagnosed with Obsessive Compulsive Disorder (OCD), Major Depressive Disorder and Social Anxiety Disorder. Appellant also reports serious issues with an overactive bladder. Appellant is prescribed the medications Ativan, Colace, and Cymbalta. (Exhibit A, p 24; Testimony)

3. Appellant lives alone in an apartment. Appellant reports that she does not leave her apartment due to her OCD and Social Anxiety Disorder for any purpose, including doctor's appointments. Appellant requests that all services be provided to her in her home. (Exhibit A, p 18; Testimony)

4. Between [redacted] Appellant was scheduled to receive CLS services once per week for a period of three hours. During that period, Appellant participated in CLS services one time, her provider rescheduled services one time and Appellant refused CLS services 12 times. (Exhibit A, pp 1-14; Testimony)

5. On [redacted], CMH sent Appellant an Appeal Acknowledgement following Appellant's filing of a local appeal. The Acknowledgement indicated that the appeal involved the amount, scope and duration of Appellant's CLS services and could not address scheduling issues Appellant had with her CLS provider. (Exhibit B; Testimony)

6. On [redacted], CMH sent Appellant an Appeal Determination which outlined the results of Appellant's local appeal. In the Determination, CMH indicated that it appeared as if Appellant's needs would be better met by individual therapy, as opposed to CLS, given that Appellant did not need assistance in learning how to conduct the tasks she needed assistance with, she simply had difficulty conducting the tasks because of her OCD. The Determination also indicated that if Appellant needed her CLS services to start at a later time, her provider could accommodate that, but it might require the assignment of a new CLS worker. (Exhibit C; Testimony)

7. On [redacted], CMH also sent Appellant an Advance Action Notice informing her that her CLS services were being terminated effective [redacted] because CMH determined that the services were no longer medically necessary because Appellant was not utilizing those services. (Exhibit A, p 15; Testimony)

8. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit 1)

9. On [redacted], CMH conducted a utilization review in preparation for the hearing, which supported the termination of Appellant's CLS. (Exhibit A, pp 17-26; Testimony)

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…

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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Health and Human Services to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Section, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual (MPM) sets out the medical necessity eligibility requirements, in pertinent part:

> **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. MEDICAL NECESSITY 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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

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.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Chapter*
> *October 1, 2015, pp 12-14*

CMH's Behavioral Health Coordinator testified that he conducted the Utilization Review (UR) following the receipt of Appellant's Request for Hearing. CMH's Behavioral Health Coordinator indicated that he is a Licensed Masters Social Worker (LMSW) and is also a Certified Advanced Alcohol and Substance Abuse Counselor. CMH's Behavioral Health Coordinator testified that he reviewed all relevant documentation in Appellant's file in conducting the UR, including notes from Appellant's providers. CMH's Behavioral Health Coordinator concluded that the termination of Appellant's CLS services was proper because, given Appellant's failure to utilize her services, those services could not be considered medically necessary under the criteria outlined in the MPM.

Appellant testified that it was not technically accurate to say that she refused her CLS services. Appellant explained that because of her conditions, she was normally unable to utilize the services as scheduled. Appellant indicated that in the past, her CLS services had been scheduled twice per week at 2:00 p.m. for two hours each appointment, and that she was better able to utilize the services at that time. Appellant testified that when her CLS services were changed to one day per week for a three hour time period beginning at 1:00 p.m., she knew it would be nearly impossible for her to engage in the services. Appellant indicated that because of her OCD, anxiety and bladder issues, it is impossible for her to get ready for the appointment at 1:00 pm and impossible for her to work with the CLS worker for three hours straight. Appellant indicated that she raised her concerns with CMH and her provider, but nothing was changed. Appellant testified that she missed the appointments in question because she was running late on those days and the CLS worker informed her that if she was more than 15 minutes late, the entire appointment needed to be cancelled. Appellant indicated that in home help is absolutely necessary for her to remain independent in her own home and that she has been placed in AFC homes in the past and it was simply unbearable given her conditions. Appellant also indicated that she has never refused any medications that might help her and has tried over 10 different medications for her OCD. Appellant testified that most of the medications had such severe side effects she could not take them. Appellant indicated that she is simply in survival mode every day and is just trying to maintain her apartment and independence.

Appellant must prove by a preponderance of evidence that the termination of her CLS services was improper. Based on the evidence presented, Appellant was unable to do so. CMH provided credible evidence that its termination of Appellant's services was proper given that Appellant failed to utilize the services provided over an extended period of time. While Appellant certainly believes that she has good reasons for failing to utilize the services as scheduled, that does not mean that it was improper for CMH to terminate the services. The scheduling of Appellant's CLS services are separate from the amount, scope and duration of those services, and CMH attempted to assist Appellant in changing her CLS schedule, although that would have involved a new CLS worker; something Appellant was not interested in. As indicated above, to be medically necessary, services must be: intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder, expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or be designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve goals of community inclusion and participation, independence, recovery, or productivity. If Appellant was not using the services provided, then the services were not medically necessary because they were not treating her condition, arresting the progression of her condition, or helping her to achieve independence and community inclusion. As such, the CMH's decision must be upheld.

As indicated during the hearing, Appellant is free to request that her CLS services be authorized again in the future and free to work with CMH and its provider to work out a schedule that better fits with Appellant's needs. It was also indicated during the hearing that a limited guardianship was ordered for Appellant at a hearing during the past week. Hopefully, the guardian will be able to assist Appellant with reengaging with services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

CMH's termination of Appellant's CLS services was proper.

IT IS THEREFORE ORDERED that:

CMH's decision is **AFFIRMED**.

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

Date Mailed: [redacted]

cc: [redacted]

RJM/clg

***** 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.