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:

Docket No. 15-010553 CMH

[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 his own behalf. Attorney [redacted] represented Respondent [redacted], Autism Coordinator and Fair Hearings Advisor, and [redacted], Community Mental Health Access Center Supervisor, testified as witnesses for Respondent. [redacted], Fair Hearing Officer, was also present.

ISSUE

Did Respondent properly deny Appellant's request for additional services and terminate his previously authorized 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 post-traumatic stress disorder; panic disorder with agoraphobia; cannabis abuse; and borderline personality disorder. (Exhibit A, page 12).

2. Appellant is enrolled in the Medicaid Health Plan (MHP), [redacted]. (Testimony of Appellant).

3. Appellant has also been receiving medication review services through Respondent, a Prepaid Inpatient Health Plan (PIHP). (Exhibit A, page 10; Testimony of [redacted]).

4. On or about [redacted], Appellant requested outpatient therapy services through Respondent and an assessment was performed. (Exhibit A, pages 9-10).

5. During that assessment, it was noted that Appellant had a history of aggression leading to property damage or verbal altercations, but that he indicated that he has learned to avoid situations that lead to aggression. (Exhibit A, pages 9-10).

6. It was also noted that Appellant was consistently attending his medication reviews and that, while he had some complaints of anxiety and difficulty sleeping, he was generally stable. (Exhibit A, pages 9-10).

7. It was further noted that Appellant had lingering chronic pain and medical issues arising from a fire in the year [redacted], and that he needed assistance with Activities of Daily Living; learning and recreation; and interpersonal functioning. (Exhibit A, pages 9-10).

8. Based on that assessment, Respondent determined that Appellant's request for outpatient therapy services should be denied and his medication review services should be terminated because he no longer met the criteria for services through the PIHP. (Testimony of [redacted]

9. On [redacted], Respondent sent Appellant written notice of its decision. (Exhibit 1, page 2; Exhibit A, page 4).

10. That same day, Appellant filed a local appeal regarding Respondent's decision. (Exhibit A, pages 3, 5).

11. On [redacted], Respondent sent Appellant written notice that his local appeal had been denied. (Exhibit A, pages 3, 5).

12. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (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…
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> *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.

Here, Respondent is a PIHP that provides services pursuant to its contract with the Department. Eligibility for services through Respondent is set by Department policy, as outlined in the Medicaid Provider Manual (MPM), and the MPM states in the pertinent part that:

> **1.6 BENEFICIARY ELIGIBILITY**
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> *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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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.

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.
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> 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.
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> 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.
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> *MPM, April 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 3-4*
> *(Emphasis added by ALJ)*

The State of Michigan's Mental Health Code defines 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

Pursuant to the above policies and statute, Respondent denied Appellant's request for additional services and terminated the services he did have on the basis that he is not a Medicaid beneficiary with a serious mental illness, serious emotional disturbance or developmental disability whose needs exceed the benefits of the MHP he is enrolled in.

Specifically, [redacted] testified that, while Appellant had a history of threats and violence, there had not been any such incidents in the past year; Appellant was now stable; and he had achieved the goals in his plan of service. [redacted] also testified that other resources in the community could meet Appellant's current needs as Appellant had connected with his primary care physician, who could prescribe him medications, and Respondent had also provided him with a list of providers. [redacted] further testified that Respondent maintains an ongoing list of counselors who participate with MHPs, including Appellant's MHP, and that the list was provided to Appellant.

In response, Appellant testified that, while his family doctor can and will prescribe his medications, Respondent is the only place where he can see a doctor and therapist in the same location. Appellant also testified that he is getting worse; it is hard for him to leave the house; and he does not get enjoyment out of anything.

Appellant bears the burden of proving by a preponderance of the evidence that Respondent erred in making its eligibility determination. 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 be affirmed.

It is undisputed that Appellant previously met the criteria for services and that he has been diagnosed with post-traumatic stress disorder, panic disorder with agoraphobia and borderline personality disorder. However, Appellant did not demonstrate that his symptoms continue to be severe or result in substantial functional limitations. Appellant's issues with aggression have stabilized; he expressly indicated that he has learned to avoid situations that lead to aggression; and he has not had any incidents in the past year. Additionally, while Appellant also testified during the hearing regarding his worsening agoraphobia, he only described mild or moderate psychiatric symptoms.

It is undisputed that Appellant's primary care physician can manage his medications and that Respondent referred Appellant to counselors that work with his MHP. Moreover, while Appellant also testified that he wants his doctor and therapist to be at the same location, which is only possible through Respondent, the convenience of having his providers in the same location does not demonstrate medical necessity for such an arrangement or for services through Respondent.

Appellant has therefore failed to show that his needs exceed his MHP benefits and Respondent's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent both properly denied Appellant's request for additional services and terminated the services he was previously authorized for.

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]

[redacted]
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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.