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:

MAHS Docket No. 15-020976 CMH

[redacted] [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 hearing.

After due notice, a telephone hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted] Appellant's mother, also testified as a witness for Appellant. [redacted] Manager of Due Process, represented the Respondent [redacted] [redacted], a psychologist with [redacted]' Utilization Management, testified as a witness for [redacted].

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 twenty-three-year-old Medicaid beneficiary who has been diagnosed with schizoaffective disorder; posttraumatic stress disorder; panic disorder; and borderline personality disorder. (Exhibit 2, page 1; Exhibit A, pages 7, 21).

2. Appellant had been receiving services through [redacted], including targeted case management; medication reviews; and outpatient therapy. (Exhibit A, page 26).

3. However, while authorized for medication reviews, Appellant did not take any medications because she has overdosed in the past and panicked at the thought of it happening again. (Exhibit 2, page 1; Exhibit A, page 36; Testimony of Appellant).

4. Appellant regularly attended her outpatient therapy sessions. (Exhibit 2, page 1; Exhibit A, pages 36, 40, 44, 48).

5. Appellant also regularly attended her targeted case management meetings and, during those meetings, the case manager noted some stress regarding money and relationships, but also consistently found that Appellant was doing well and had no serious symptoms. (Exhibit A, pages 27-70).

6. On [redacted], Respondent's psychologist conducted a review of Appellant's services. (Exhibit A, pages 1-3).

7. The review was triggered by Appellant's lack of medications and clinical psychiatric services. (Testimony of Respondent's witness).

8. During that review, Respondent's psychologist looked at the most recent psychiatric evaluation in Appellant's file, which had been conducted by a doctor on [redacted] and in which the doctor noted that Appellant disputed some of her diagnoses; Appellant had been off all medications since [redacted]; and that there was no charting of any remarkable symptoms. (Exhibit A, page 2; Testimony of Respondent's witness).

9. Respondent's psychologist also looked at the notes of Appellant's case manager and therapist, and found that they only described some residual symptoms of anxiety and panic. (Exhibit A, pages 2-3; Testimony of Respondent's witness).

10. Following her review, Respondent's psychologist determined that Appellant no longer met the criteria for services through [redacted] and that her services should therefore be terminated. (Exhibit A, pages 2-3).

11. She also noted that Appellant could receive any necessary outpatient therapy through the Medicaid Health Plan (MHP) she was enrolled in, [redacted], which also participates with the therapist Appellant has been seeing. (Exhibit A, pages 2-3).

12. On [redacted] sent Appellant written notice that her services would be terminated effective [redacted]. (Exhibit A, pages 4-6).

13. Regarding the specific reason for the denial, the notice stated:

> Upon review, you no longer present as eligible for services through [redacted] as a person with either a severe mental illness or a developmental disability. You have a Medicaid health plan, [redacted], and the service you appear to need (outpatient

> counseling) is benefit covered by your MHP. You may remain at [redacted]. [redacted]) as a [redacted]HP provider for that service as needed, if you desire.

Exhibit A, page 4

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

15. On [redacted] the termination took effect. (Testimony of Appellant).

16. Since that time, Appellant has been seeing the same therapist as before, but now it is through her MHP and only every two weeks. (Exhibit 2, page 1; Testimony of Appellant).

17. On [redacted] Appellant's therapist wrote a letter stating in part:

> I have been working with [Appellant] as her therapist for the last few years. After she started [redacted] with me after being transferred to me from another therapist she completed [redacted] and has returned to [redacted]T. She has been very consistently coming and making improvement but cutting her services has set her back. She has been more reactive to her emotions and her paranoia has increased. The support from case management helped her start working toward her high school diploma to work toward getting off SSI. She chooses not to take medication due to the panic it causes in her. She rarely takes any prescription medications even when sick. After an overdose, she has not been able to take any medication without high anxiety as it triggers feelings of being out of control. She feels she is being punished for making this choice. Treatment is suppose to be person centered and she has worked hard to improve with case management and therapy.

Exhibit 2, page 1

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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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 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	▪ 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

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.	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.
>
> 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, October 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

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(25)*

Here, [redacted] terminated Appellant's services pursuant to the above policies and statutes. In particular, both its notice of denial and the testimony of its witness during the hearing stated that, based on the information submitted, Appellant did not meet the above criteria for a serious mental illness, serious emotional disturbance or developmental

disability and, while she does have mild to moderate mental health needs, those needs can be met through Appellant's MHP. The witness also testified that, while the review in this case was triggered by Appellant's lack of medications and clinical psychiatric services, being on medications or receiving psychiatric services is not a requirement for services and the decision was not based on that fact. Instead, the decision was based on the fact that Appellant's records demonstrate that, while Appellant may have met the criteria for services years ago, she has since stabilized and only has mild, residual symptoms.

In response, Appellant explained why she does not take any medications, due to a past overdose, and testified regarding her current symptoms. Specifically, Appellant testified that she still has panic attacks and, while they are not constant, they are severe. Appellant also testified that she still has mood swings, especially lately, and that her depression makes it difficult for her to have energy to do anything except care for her son. Appellant did testify that she is able to care for her son; attend school, mostly online; and that she does own her home. Regarding the last psychiatric evaluation, Appellant testified that she did tell the doctor that the diagnosis of schizoaffective disorder is incorrect and that she does not have auditory hallucinations or delusions, but that she did not deny a history of paranoia and still has such paranoia. Regarding her case management, Appellant also testified that her case manager is someone to talk to and has helped her get back into school.

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

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that Respondent's decision must therefore be affirmed. The MPM divides coverage responsibilities in this case between [redacted] and Appellant's MHP and, while whether Appellant takes medications is irrelevant to that determination, the severity of Appellant's symptoms is not and, here, Appellant must seek services through her MHP as she only appears to be experiencing mild or moderate psychiatric symptoms and limitations on functioning. For example, there is nothing in the case manager's notes regarding any severe symptoms, just some stress, and, while the case manager previously assisted Appellant in getting back in school, the case manager was not providing any specific assistance, other than talking, at the time of the termination in this case. Similarly, while Appellant credibly testify regarding current symptoms, she also acknowledged that, even with those symptoms, she is able to care for her son and attend school. The most recent psychiatric evaluation further reflected that Appellant did not have any severe symptoms as of from [redacted] and it is undisputed that Appellant only continued to improve after that time. Moreover, while there were no notes from the therapist are in the record, Respondent's witness credibly testified that she reviewed them and they also failed to identify any current, severe symptoms, while the letter from the therapist that was entered into the record only identified broad issues

and lacked any specific details about the severity of Appellant's remaining symptoms and their effect.

If Appellant exhausts her services through the MHP or Appellant's 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**.

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

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.