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. 15-021355 CMH

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 Appellant appeared and testified on his own behalf. Appellant's sister; , Appellant's Case Manager; and Appellant's Peer Supports Specialist; also testified as witnesses for Appellant. , Manager of Due Process, represented the Respondent , Utilization Management Coordinator, testified as a witness for

ISSUE

Did the 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 is enrolled in a Medicaid Health Plan (MHP), . (Exhibit A, pages 1, 9).

2. Appellant has also been receiving services through including supports coordination, medication management, and peer support services. (Exhibit A, pages 7-8).

3. Progress notes written by Appellant's peer supports specialist between and all indicate that Appellant is doing well, stable, has no concerns, or is living independently. (Exhibit A, pages 55-81).

4. The Quarterly Review of Appellant's services stated that he had maintained his health and safety during the quarter, had attended his appointments, taken his medications, followed any treatment recommendations, and continued to live independently. (Exhibit A, pages 37-38).

5. The Quarterly Review of Appellant's services made the same findings. (Exhibit A, pages 43-48).

6. The Quarterly Review made similar findings, while also noting that Appellant was doing okay overall and with a reduction in his medications, but that he did have some visual hallucinations recently. (Exhibit A, pages 49-50).

7. On , Respondent's Utilization Management Coordinator of Appellant's needs and services. (Exhibit A, pages 9-12).

8. During that review, she concluded that, while Appellant may have had a serious mental illness at some point in the past, his symptoms have been substantially moderated and any prominent functional impairment has largely subsided. (Exhibit A, page 12).

9. She also noted that Appellant has not had any exacerbations or use of crisis services in the past year, and that his needs can be met through his MHP. (Exhibit A, page 12).

10. On sent Appellant written notice that his supports coordination and medication management services would be terminated effective . (Exhibit A, pages 13-14).

11. Appellant's peer support services were not specifically mentioned in the notice, but they were also being terminated. (Testimony of Respondent's Utilization Management Coordinator).

12. Regarding the specific reason for the termination, the notice stated:

> you no longer meet medical necessity for a person that is severely mentally ill and needing specialty service and supports. Needs can be met in your community provided by your medicare provider / hmo.

Exhibit A, page 13

13. On , the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-3).

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.

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.

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 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.
>
> 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, ███ 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 has been receiving services since ███ and that the termination is unfair given that his mental impairments cause hallucinations, paranoia and other psychological problems, in addition to the physical impairments he also has. Appellant also testified that his medications have to be supervised and that his primary care physician will not do so and says he has to go to a psychiatrist. Appellant did acknowledge that he has not had any crises in the past twelve months, he lives alone, and that he has been stable. Appellant further testified that he stays inside a lot, dreams of death and destruction, has hallucinations, and will not engage in activities because of his depression.

Appellant's peer support specialist also testified that Appellant may present well on paper, including in progress notes she has made, but that is only because Appellant has the supports and structures he has been receiving and he tries to be positive.

Appellant's sister further testified that Appellant's mental illness is not going away with age and that, while Appellant has progressed, it is only because of the structure in his

life. She also testified that Appellant does not share everything about his impairments with other people.

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. 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.

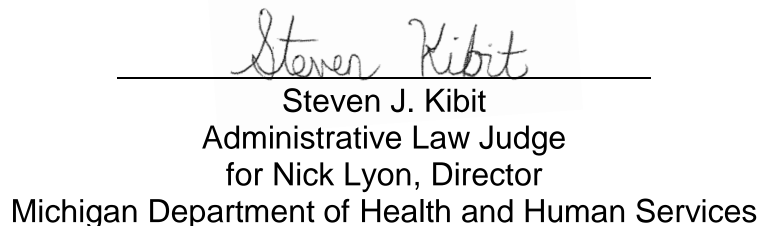
If Appellant exhausts his services through the MHP or his symptoms significantly worsen and the MHP's services are insufficient; Appellant can always re-request services through [redacted] in the future. With respect to the decision at issue in this case however, [redacted] decision to deny Appellant's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



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

Date Mailed: [redacted]

SK/db

cc:

r

*** 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.