RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 16-002562
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

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

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

[redacted], Fair Hearing Officer, [redacted], PIHP for [redacted], (formerly [redacted]) represented the Department ([redacted] or CMH).

ISSUE

Did [redacted] properly terminate Petitioner'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. Petitioner is a [redacted] year-old Medicaid beneficiary, born [redacted], who has been receiving services through HealthWest since [redacted]. (Exhibit A, p 1; Testimony)

2. Petitioner is diagnosed with schizoaffective disorder. Petitioner has problems with her primary support group, housing problems, other psychosocial and environmental problems and a GAF of 55. (Exhibit A, p 2; Testimony)

3. Petitioner was receiving supports coordination services, skill building assistance, and transportation services through HealthWest, provided by [redacted]. Petitioner had been offered additional services, including psychiatry, outpatient therapy, and vocational assistance, but those services were declined by Petitioner. (Exhibit A, p 2; Testimony)

4. Following meetings with her supports coordinator on [redacted] and [redacted], it was determined that the services being provided by [redacted] were no longer medically necessary because those services were not assisting Petitioner in meeting her goals. Petitioner agreed with this assessment and informed her supports coordinator that she no longer wished to receive services. (Exhibit A, pp 1-6; Testimony)

5. On [redacted], [redacted] provided Petitioner with a Notice of Action and Appeal Rights indicating that her services were being terminated. (Exhibit A, pp 7-8; Testimony)

6. Petitioner's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit 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 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 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 Section
January 1, 2016, pp 12-14

The Department's witness testified that Petitioner's services were discontinued effective [redacted] per Petitioner's request and following a determination that the services were no longer medically necessary because the services were not assisting Petitioner in achieving her goals. The Department's witness pointed to progress notes from [redacted] in support of the Department's action. (Exhibit A, pp 10-25)

Petitioner testified that she lives with her sister and is her own guardian. Petitioner indicated that she understood when meeting with her supports coordinator that her services would be terminated and she supported that decision.

Petitioner's mentor at [redacted] testified that he is in a bit of a quandary because Petitioner is telling him that she wants to continue her services at [redacted] but is telling [redacted] that she does not wish to continue. Petitioner's mentor at [redacted] indicated that Petitioner has made great strides with regard to socialization since beginning at [redacted] and that they also have services that could help Petitioner with her goals to live independently and find work.

Petitioner must prove by a preponderance of evidence that the termination of her services was improper. Based on the evidence presented, Petitioner was unable to do so. Here, it is clear from the evidence that the services Petitioner was receiving were no longer medically necessary because those services were not assisting Petitioner to reach her goals. Petitioner agreed with this assessment and asked that her services be terminated. Petitioner was offered alternative services, but declined those services. As such, [redacted] decision was proper based on the evidence and must be upheld.

As indicated at the hearing, Petitioner can be rescreened for services through [redacted] if she has a desire to continue with services.

DECISION AND ORDER

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

[redacted] termination of Petitioner's services was proper.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

RM/cg

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[redacted]

Petitioner

[redacted]

Authorized Hearing Rep.

[redacted]

DHHS Department Rep.

[redacted]