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Date Mailed: March 2, 2020
MOAHR Docket No.: 19-012939
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on February 4, 2020. [redacted], Petitioner's Mother, appeared on behalf of Petitioner. Petitioner appeared as a witness. Jackie Bradley, Fair Hearings Officer, appeared on behalf of Lenawee County CMSHP (Department). Jennifer Carpenter, Access Program Director, appeared as a witness for the Department.

Exhibits:

Petitioner	None
Department	A. Hearing Summary

ISSUE

Did the Department properly terminate Petitioner's psychiatric therapy 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 Medicaid beneficiary, born [redacted], who receives services through the Department. (Exhibit A, p 33; Testimony.)

2. The Department is under contract with the Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area.

3. Petitioner is diagnosed with panic disorder, generalized anxiety disorder,

agoraphobia, major depressive disorder, dependent personality disorder and alcohol use disorder. (Exhibit A, p 28; Testimony.)

4. As of October 15, 2019, Petitioner received from the Department psychiatric services and substance use disorder services. (Exhibit A, p 31; Testimony.)

5. On October 15, 2019, Petitioner participated in a bio/psycho/social assessment. Upon completion of the assessment, it was determined Petitioner was now stable and no longer met the authorization requirement for psychiatric services through the Department. At this time, it was recommended that Petitioner's psychiatric services be terminated, and Petitioner be transferred to a local provider for further psychiatric care. (Exhibit A, p 29; Testimony.)

6. On October 15, 2019, the Department sent Petitioner a negative action notice. The notice indicated Petitioner's psychiatric services would be terminated and that he would be transferred to a local provider to provide further psychiatric care. (Exhibit A, p 31; Testimony.)

7. On October 17, 2019, Petitioner submitted an internal appeal. The internal appeal indicated Petitioner's psychiatric needs could be met in the community through either a primary care physician or a community psychiatrist. (Exhibit A, p 31.)

8. On November 1, 2019, the Department issued an Internal Appeal Decision. The decision affirmed the Department's decision to terminate Petitioner's psychiatric services. (Exhibit A, p 31.)

9. On December 17, 2019, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing.

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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.[1]

The Department is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

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[1] See 42 CFR 440.230.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant 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. 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.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

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.[2]

The Department indicated the Petitioner could receive psychiatric care from either a primary care physician or other community psychiatrist as he no longer had a severity of illness that required ongoing psychiatric services through the Department. The Department indicated the Petitioner was now stable and no longer required medication changes.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in terminating his psychiatric services. Based on the evidence presented, Petitioner has failed to meet this burden. Petitioner's primary argument addressed substance abuse concerns. In this case, Petitioner's substance abuse services were not going to be affected. Additionally, the documentation provided corroborates the Departments testimony and supports their position. Consequently, I find sufficient evidence to affirm the Department's decision to terminate Petitioner's psychiatric services.

[2] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, January 1, 2020, pp 14-15.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly terminated Petitioner's psychiatric services.

IT IS THEREFORE ORDERED that:

The Department decision is AFFIRMED.

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS-Location Contact

Kathryn Szewczuk
Lenawee County CMHSP
1040 South Winter St
Adrian, MI
49221-3867

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
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DHHS Department Rep.

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Petitioner

[redacted]

Authorized Hearing Rep.

[redacted] MI