STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],

Appellant

_____/

Docket No. 2009-20050 CMH
Case No. [redacted]
Load [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. [redacted] was represented by [redacted]. [redacted] represented the Department's contracted Pre-paid Inpatient Health Plan (PIHP), [redacted]. [redacted] was present and testified. [redacted] attended and provided testimony on behalf of the Department.

ISSUE

Did [redacted] properly terminate the Appellant's authorization to participate in [redacted] programming?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary.

2. [redacted] is a PIHP and contractor of the Michigan Department of Community Health (MDCH). [redacted] is an affiliate of the [redacted].

3. [redacted] is to provide Medicaid covered services to the Medicaid eligible clients it serves.

4. The Appellant is a [redacted] woman diagnosed with a mental illness who lives independently in the community with her family.

5. The Appellant has been a participant in the [redacted] available for eligible [redacted] clients. She has participated in the kitchen unit of the program.

6. The Appellant has a neurological disorder that has rendered her dependent on a wheelchair for mobility.

7. The Appellant has some limited ability to stand up and out of her wheelchair.

8. The Appellant has attempted to and stood up out of her wheelchair on numerous occasions while at the [redacted]. She does not always apply the brakes to her wheelchair.

9. When the Appellant does not apply the brake to her wheelchair, she has fallen when attempting to stand up and/or get out of the chair.

10. The Appellant has fallen on numerous occasions due to failing to apply the brake to her wheelchair.

11. The Appellant places her physical well being at risk when she attempts to stand up out of the wheelchair without placing the brake first.

12. The Appellant will frequently leave the [redacted] and go outside for the purpose of smoking. The parking lot and driveway are steep, causing her to roll into unsafe, traffic ridden areas within the parking lot.

13. The Appellant has been reminded repeatedly about using the brake on her wheelchair. She has been asked not to go outside where it is dangerous.

14. The Appellant has had the safety concerns, specifically pertaining to her use of the wheelchair in her most recent Individualized Plan of Service (IPOS).

15. In [redacted], following an incident wherein the Appellant fell in the parking lot area, along with another [redacted] participant, the Appellant's authorization to participate at [redacted] was suspended due to safety concerns.

16. The Appellant was notified her [redacted] use was suspended due to her inability to meet the standard promulgated by MDCH indicating a beneficiary must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff to member ratio.

17. The Appellant has had multiple assessments conducted in order to ascertain whether there was another service or intervention available that would allow her to participate in [redacted] in conformity with the requirement she not have behavioral issues preventing safe participation.

18. [redacted] determined there was no service or additional intervention available that would allow the Appellant's use of [redacted] in conformity to the MDCH requirements as published in the Medicaid Provider Manual.

19. The Appellant appealed the [redacted] determination to terminate her [redacted] authorization, requesting a formal, administrative 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.
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> *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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [redacted] contracts with the Michigan Department of Community Health to provide services under the HSW. [redacted] is an affiliate of [redacted]. Services are provided by [redacted] pursuant to its contract obligations with the PIHP/Department. Medicaid recipients are to be provided medically necessary services appropriate in scope, amount and duration to reasonably achieve their stated purpose. The Department's policy regarding Medical Necessity follows below:

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.

Medicaid Provider Manual; Mental Health/Substance Abuse; Version Date: July 1, 2006; Pages 12 through 14

SECTION 5 – CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary (also called clubhouse "members"), with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community. Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

5.1 PROGRAM APPROVAL

PIHPs must seek approval for providers of psychosocial rehabilitation clubhouse services from MDCH.

(Refer to the Directory Appendix for contact information.) MDCH approval will be based on adherence to the requirements outlined below.

5.2 TARGET POPULATION

> Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, **and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to-member ratio.** (Emphasis supplied by ALJ)
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> Medicaid Provider manual Mental/ Health Substance Abuse ; Version Date July 1, 2009 Page 29

A review of the evidence of record found most credible and relevant supports the position taken by the Department. The Department has provided ample evidence of the Appellant's non-compliant behaviors that result in risk of harm to herself and now, other [redacted] participants. The Appellant did not contest during the hearing that she does not always engage the brake of her wheelchair. Her father asserted the non-compliance is part of her mental illness, therefore must be treated. He also asserted the inconsistent position that she simply forgets to put the brake on at times. In this case, given the amount of time that has been spent attempting to gain the Appellant's compliance with the simple request that she not attempt to get out of her chair without putting the brake on and the failure to obtain her cooperation in this matter, it is evidence her lack of compliance is voluntary. The issue, along with other safety issues such as leaving the premises to go outside into the parking lot, which is sloped, has been addressed in her IPOS. It has been addressed with her verbally as well, with "reminders" as often as practical given the low staff/participant ratio. This ALJ solicited the Appellant's direct testimony on the matter. She stated she does not always apply the brake before attempting to get out. She did not provide persuasive evidence it was merely a matter of honest forgetfulness. She did not provide credible, persuasive evidence she had made an honest effort to be compliant and failed due to medically based forgetfulness that is beyond her control. Thus, any assertion from her father that her behavior is medically based is left as merely an assertion. The assertion that it is caused by her mental illness, thus must be treated does not mean that she is be allowed to continue participation in [redacted]. While her mental illness must be treated with medically necessary services appropriate in scope, duration and amount to reasonably achieve the treatment goals, this does not mean she is able to participate at [redacted] regardless of what behaviors she engages in. [redacted] is designed for mentally ill persons, thus it presupposes its participants will have components of mental illness affecting their conduct. The Medicaid Policy still requires the participants to conform their conduct such that they are not placing themselves or others at risk.

The Appellant has not met her burden of proof and established that she be allowed to continue participation in [redacted] at this time due to her lack of willingness to refrain from conduct that places her own and others' physical well being at risk.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's action in terminating the Appellant's authorization to participate in [redacted] programming was proper.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/22/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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.