STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

[redacted]

Appellant
_____/

Docket No. 2009-23251 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 on [redacted]. [redacted] advocate, appeared on behalf of the Appellant, who was present and testified. [redacted] represented the Department. Her witnesses were [redacted], [redacted]

PRELIMINARY MATTER

At hearing the Appellant offered proposed Exhibit #2 which was objected to by the Department on the grounds that it represented new information not timely submitted. The objection was taken under advisement. On review Appellant's Exhibit #2 is admitted subject to weight.

On review the ALJ afforded this exhibit little weight.

ISSUE

Did the Department improperly deny medically necessary services [25-hours of temporary additional staffing and PERS] to the Appellant?

If so, when was the Department required to act?

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 [redacted] Medicaid beneficiary, currently enrolled in the Habilitation and Supports Waiver, who is receiving services through [redacted]. She suffers from Spinal Muscular Atrophy. (Department Exhibit A, p. 7)

2. The Appellant resides in a private residence with her partner. Her support system consists of her partner, family, co-workers, church family, and others. She requires assistance with all independent living tasks. (Department's Exhibit A, pp. 10-18)

3. According to a prior Person-Centered Plan (PCP), the Appellant's medical condition results in progressive muscle weakness. She also suffers from sleep apnea secondary to respiratory muscle weakness for which she receives breathing treatments with a ventilator. Her strengths include computer skills and a graduate degree in Social Work. She also runs a life coaching business out of her home. The Appellant's PCP also provides for 11 hours per day of Medicaid-funded personal care assistance. (Department's Exhibit A, pp. 34-44)

4. On March 18, 2009, [redacted] issued a Decision and Order in which he reversed the CMH's denial of the Appellant's request for a voice-activated environmental control system. (Department's Exhibit A, pp. 34-44)

5. During the January 3 and February 3, 2009, hearing the Department through its witness [redacted] opined that the more appropriate and cost effective service for the Appellant was for a CLS worker to regularly assist the Appellant to turn side to side while in bed - instead of purchasing an $11,000 voice-activated control system. (Department's Exhibit A, pp. 34 and 96)

6. In the preparation[1] of her [redacted], PCP the supports coordinator, [redacted], testified that she was aware of the Appellant's request for additional temporary staffing pending receipt of Request for Rehearing/Reconsideration.

7. The Appellant's verbal request for temporary staffing was acknowledged on [redacted] and was memorialized on execution of her PCP on [redacted]. (Department's Exhibit A, pp. 20, 28 and See Testimony of Cortes)

8. The request for an additional 25 hours of staffing was denied by the Department on or about [redacted]. (See Testimony and Department's Exhibit A, p. 2)

[1] Execution of the PCP dated [redacted] did not occur until [redacted] See Testimony of [redacted]

9. The request for additional temporary staffing was known and acknowledged by the Department prior to its request for Rehearing/Reconsideration of [redacted] (Department's Exhibit A, p. 89 and See Testimony)

10. On [redacted], the State Office of Administrative Hearings and Rules, Administrative Hearings for the Department of Community Health (SOAHR) received the CMH's Request for Rehearing/Reconsideration.

11. On [redacted], the Appellant requested an increase in staffing pending the outcome of the appeal brought by the Department. (Appellant's Exhibit #1)

12. On [redacted] the instant appeal was received by SOAHR. (Appellant's Exhibit #1)

13. Post appeal on [redacted] the State Office of Administrative Hearings and Rules, Administrative Hearings for the Department of Community Health granted the CMH's request for reconsideration and issued a Notice of Reconsideration reversing [redacted]. (Department's Exhibit A, p. 97)

14. The Department reauthorized and implemented this service as a [non-temporary] support on [redacted], to assist the Appellant and as a substitute for the environmental control system ordered by [redacted] (Department's Exhibit A, pp. 2, 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 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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation and Supports Waiver. [redacted] contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

The Appellant is enrolled in the Habilitation and Supports Waiver (HSW). Enhanced Medical Equipment is a covered service. Section 15 of the Medicaid Provider Manual, Mental Health/Substance Abuse, provides, in pertinent part, as follows:

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

> The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.
>
> Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.
>
> Medicaid Provider Manual (MPM); § 15 Mental Health [ ]; July 1, 2009; Page 80[2]

Furthermore, the [redacted] stresses the requirement for determination of individualized service(s) to avoid cost shifting and denials owing to preset pecuniary limits:

> **2.5.D. PIHP DECISIONS**
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> 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.
>
> MPM; Mental Health [ ]; July 1, 2009; Page 14.[3]

[2] This version of the [redacted] is identical to the edition in place at the time of the instant appeal, [redacted] 2009.

In this case the parties agreed to an incidental agreement to provide a support/service "temporarily." The agreement was known by the parties as early as [redacted] and addressed a temporary need for a 25-hour a week increase in staffing for the Appellant and a PERS system. The Appellant rejected the idea of a PERS system for reasons not in dispute – but the Department denied the Appellant's request for those CLS services on [redacted] - even though understood to be medically necessary.

The Department focused on an agreement broached by the Appellant to limit the duration of the temporary grant to its receipt of [redacted] Order of Reconsideration. [Received by the Department on [redacted]]. The date of [redacted] decision is not in dispute.

The facts, the evidence and the conduct of the parties clearly showed that the Department and the Appellant entered into a mutually[4] consensual oral agreement later reduced to writing where the Department agreed to provide additional staffing for the Appellant – because she needed additional hands-on assistance not resolvable by technological assistive devices. *See* Department's Exhibit A, pp. 20-28, 44, 45, 57, and 61.

On Reconsideration/reversal – the stipulation was extinguished by its own terms and the jurisdictional limits of SOAHR. Had [redacted] decision been affirmed by [redacted] the stipulation would have been resolved by implementation of [redacted] order mandating an electronic system versus the hands-on methodology promoted by [redacted] in the original hearing. Either way, the Appellant's medical necessity for additional services remained extant.

At hearing the Department claimed that the agreement to provide 25-additional hours of staffing was in effect on or about [redacted]

The Appellant claimed that the agreement was in effect on the date of [redacted] decision and order [redacted] All of the testimony established that the proposed temporary staffing gambit was known by the Department representatives as early as [redacted] but it was not reduced to writing approved until later.

The Appellant's need for assistance (25-temporary hours of additional weekly assistance) attached on [redacted]

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[3] See Also MPM §15.2 Supports Coordination - "…maximization of income/benefits [and] implementation of supports and services" at page 93.

[4] "The mutuality requirement is satisfied where a modification is established through clear and convincing evidence of a written agreement, oral agreement, or affirmative conduct establishing mutual agreement to waive the terms of the original contract." *Quality Products v, Nagel Precision, Inc.*, 69 Mich 362, 373 (2003)

Today, the clear weight of the evidence demonstrates that he Appellant had a medically necessary need for additional hands-on (CLS) services because there were tasks she could no longer do which could not be addressed with either a PERS system or a Voice Activated system.[5]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department did agree to provide additional temporary staffing [25-hours additional staffing per week] for the Appellant.

The time frame for that temporary agreement was [redacted]

[Additional non-temporary staffing needs, 25-hours additional staffing per week, remain in effect until expiration of the Appellant's current personal care plan].

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/17/2009

[5] The Appellant did not want the PERS system for personal reasons and the Department had argued earlier that the Voice Activated system originally sought by the Appellant was not capable of providing some necessary tasks which could only be provided by a person.

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.