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

Docket No. 2010-27590 CMH
Case No.

Appellant
______________________/

DECISION AND ORDER

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

After due notice, a hearing was held on . Appellant appeared on his own behalf. , Appellant's wife; and , Appellant's sister and paid CLS chore provider for Appellant's wife, appeared as witnesses for Appellant.

(CMH), Developmental Disability Supervisor, represented the CMH. , Appellant's CMH Support's Coordinator appeared as witnesses for the CMH.

ISSUE

Did CMH properly terminate Appellant's supports coordination and deny his request for community living supports?

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. The Appellant is enrolled in

3. Appellant and his wife live with Appellant's sister, . Appellant's sister is also paid CLS chore provider for Appellant's wife.

4. Appellant is able to access the community on his own through public transportation.

5. Appellant has had money management training, has a payee and desires to control his own finances. (Exhibit 1, 3-38).

6. Appellant is able to perform his own activities of daily living; including dressing, bathing and grooming. (Exhibit 1, 3-38).

7. Appellant has natural supports; including his sisters and sister-in-law. (Exhibit 1, p 5).

8. Appellant was receiving supports coordination services (CS) in . (Exhibit 1, pp 3-38).

9. Appellant requested and was denied community living supports (CLS) from CMH at least two (2) times in , prior to current denial, for not meeting medical necessity criteria. (Exhibit 1, pp 3-38).

10. Appellant has history of developmental delay, including mild mental retardation. (Exhibit 1, p 12).

11. As Appellant has linked to or achieved services provided by supports coordination CMH determined his supports coordination case could be closed. (Exhibit 1, 3-38).

12. On , the CMH sent an Adequate Action Notice to the Appellant indicating that his supports coordination services would be terminated and his request for community living supports would be denied. (Exhibits 1, pp 1-2).

13. The Appellant's request for hearing was received on . (Exhibit 2).

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 CS 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 (CS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Community Health 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 CMH supports coordinator witness Bingaman testified that because the Appellant utilized his supports coordination services and was now linked to or achieved items that are covered services, for example money management (has a payee) and shelter (recently moved in with his sister), his supports coordination would be terminated.

The CMH witness explained that because Appellant knew how to use public transportation to access the community and had natural supports, Medicaid funds could not be used to pay for community living services available by natural supports. The CMH witness indicated that the Appellant frequently requested and been denied CLS because Medicaid funds cannot be used to pay for services available by natural supports. (Exhibit 1, 41-45).

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, 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.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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2010, page 13.

The Appellant testified that had a hard time reading and has a bad memory. The Appellant's sister and paid CLS chore provider for Appellant's wife said she has to provide the same services for Appellant as she provides for Appellant's wife and she thought she should get paid for CLS services for both. The Appellant's sister described that she had to drive Appellant to his doctor's appointments and had to tell the Appellant what day it was when he called her one time.

The CMH witness clarified that CLS cannot use Medicaid to pay for transportation to medical appointments. The CMH witness said when he asked Appellant what he needed CLS for the Appellant answered to help him wear appropriately matched clothes. The CMH witness explained that supports coordination is intended to link to community services and Appellant is currently linked to services he needs. (Exhibit 1, p 45).

During the hearing, the CMH introduced policy to supports its position. (Exhibit 1, 39-45). Evidence of record supports the fact that Appellant was authorized for CMH supports coordination and requested community living supports but he either is able to perform the tasks himself or has natural supports to help him. (Exhibits 1, 3-38).

The Appellant must prove by a preponderance of evidence that the CMH termination of Appellant's supports coordination and denial of his request for community living supports was not proper, but he did not do so. The CMH provided credible evidence that its [redacted], termination of supports coordination and denial of community living supports was proper.

DECISION AND ORDER

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

> The CMH's termination of Appellant's supports coordination and denial of his request for community living supports was proper.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

____
Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/15/2010

***** 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.