**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:

Appellant
_______________________/

Docket No. 2011-16968 CMH
Case No. 16116867

# 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 . , the Appellant's , appeared on behalf of the Appellant.

(CMH), represented the CMH. ; ; and , appeared as witnesses for the CMH .

## ISSUE

Did the CMH properly terminate the Appellant's supports coordination, community living supports, and therapy services; and authorize medication clinic 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. The Appellant is Medicaid beneficiary. (Exhibit 1)
2. The Appellant has a history of mental retardation and bipolar disorder. (Exhibits 6, 7)

3. The Appellant's representative at the hearing is his , . (Exhibit 1)

4. In and prior to the Appellant was enrolled in and received services from (CMH). The CMH contracts with ) to provide supports coordination and other mental health services for its Medicaid mental health enrollees.

5. In order for Medicaid to pay for mental health services the Medicaid beneficiary must have the current annual person-centered plan, developed jointly between the Appellant and the CMH. (Michigan Mental Health Code)

6. The amount, scope and duration of Medicaid covered services are determined by an annual assessment. The results of the annual assessment are used to determine the services to be authorized. The authorization vehicle is the person-centered plan. (Code of Federal Regulations)

7. The Appellant's person-centered plan expired in or around . At expiration of his person-centered plan, the Appellant's CMH services authorization ended. (Exhibit 4)

8. In or around the Appellant's Supports Coordinator attempted to schedule an appointment with the Appellant, the Appellant's and the Appellant's to complete an annual assessment needed to develop Appellant's person-centered plan. (Exhibits 1, 4, 7)

9. Between and , the Appellant's Supports Coordinator made several attempts to schedule the assessment needed for development of the Appellant's person-centered plan, but Appellant's did not follow through on making Appellant available for the assessment. (Exhibit 4).

10. Because the Appellant had no person-centered plan in , and , he had no authorized services, and was receiving no other services except for medication clinic.

11. In and the Appellant had no assessment and no person-centered plan.

12. Despite having no authorized services other than medication clinic, the Appellant's condition was stable in and . (Exhibit 4).

13. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating that his supports coordination, community living supports, and therapy would be terminated; and that his medication clinic/psychiatric services would be authorized. (Exhibit 1, pages 3-4).

14. The Appellant's request for hearing was received on [redacted]. The request was filled out by the Appellant's [redacted] and requested an expedited hearing. The expedited hearing was granted. (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 Michigan 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.

Medicaid beneficiaries are only 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. *See 42 CFR 440.230.*

The federal Code of Federal Regulations, the state Mental Health Code, and Michigan Medicaid policy mandate that appropriate amount, scope and duration is to be determined through the person-centered planning process. It is indisputable that the federal regulations, state law, and policy, require the cooperation of both the Community Mental Health and the Medicaid beneficiary in the person-centered planning process.

The CMH and the Medicaid beneficiary are bound by the Code of Federal Regulations, the state Mental Health Code, and state Medicaid policy. As such, both parties must cooperate in the development of a person-centered plan before Medicaid services can be authorized.

The CMH contends that the Appellant's [redacted] and the Appellant's [redacted] both failed to cooperate in the assessment necessary to develop a person-centered plan, despite six months of attempts to schedule the person-centered plan assessment. The CMH asserts that in that six month time span in which the Appellant's PCP had expired and no services were authorized, the Appellant's condition remained stable, therefore demonstrating there is no medical necessity for services other than medication clinic/psychiatric service.

As such, the issue in this case has two parts: 1) was the CMH proper to terminate the Appellant's services after repeated attempts failed to produce a current person-centered plan; and 2) did the CMH properly determine that no medical necessity was established for Medicaid-covered CMH services other than medication clinic?

> MCL 330.1712 Individualized written plan of services.
>
> (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.
>
> (2) If a recipient is not satisfied with his or his individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
>
> (3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

The CMH representative further explained that the CMH must follow the Department's Medicaid Provider Manual, when approving mental health services to an applicant, and

the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

> **2.5.B. DETERMINATION CRITERIA**
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> 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. (Underline added).

*Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, January 1, 2011, page 13.*

The CMH representative and the CMH witnesses testified that CMH followed the Code of Federal Regulations, the state Mental Health Code, and the policy as found in the *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section* to determine that the Appellant did not meet medical necessity to receive specialized mental health services provided through the CMH, and that his current services, with the exception of medication clinic, should be terminated.

The CMH witnesses' testimony corroborated each other, and was consistent with the document evidence. As such the CMH witnesses' testimony was credible and established:

- CMH scheduled a appointment to complete the PCP. On , the Appellant's canceled the appointment.
- On , the Appellant's Supports Coordinator left a telephone message for the Appellant's to return her call to schedule an appointment. The Supports Coordinator received no return call scheduling an appointment.
- On , the Supports Coordinator contacted the Appellant's to schedule a home visit to complete an annual PCP. The Appellant's indicated she would call to schedule an appointment.
- On , the Appellant's contacted the Appellant's Supports Coordinator and indicated he would speak with the Appellant's regarding scheduling an appointment to complete the Appellant's annual PCP.
- On , the Appellant was scheduled for a medication clinic visit and his Supports Coordinator attempted to schedule the PCP that same day. On , the Appellant's refused the PCP meeting that day stating someone else should attend the meeting.
- On , the Supports Coordinator contacted the Appellant's home to schedule an appointment to complete the PCP, and the psychosocial assessment. The Supports Coordinator spoke with the Appellant's and scheduled an appointment for .
- On , the Appellant's and the Appellant missed the scheduled appointment, despite the Supports Coordinator attempting to contact the Appellant's by telephone.
- On and , Appellant's Supports Coordinator telephoned the Appellant's to reschedule the assessment and PCP appointment, left voicemail messages to return the call, but received no response.
- On , the Appellant's returned the call to Appellant's Supports Coordinator and indicated he needed a written

explanation informing him about the assessment process. On that same day, the Appellant's Supports Coordinator mailed to Appellant's a letter explaining the assessment and person-centered planning process, as well as a Consumer Handbook which outlined in detail the assessment and person-centered planning process.

- On , the Appellant's called the Supports Coordinator to arrange cab service for Appellant and his to attend the medication clinic that day. The Supports Coordinator made the same-day cab service arrangement for the Appellant to attend his medication clinic. When the Appellant and his arrived at the appointment, the Supports Coordinator expressed concern about the necessity of completing the PCP. The Appellant's indicated that the Appellant's would take care of making the Appellant available for his annual assessment and PCP.

- As a result of the medication clinic, the Appellant's psychiatrist concluded that the Appellant was doing well, and not having any specific problems or complaints.

- On , , , and , the Supports Coordinator attempted telephone contact with Appellant's to complete the assessment needed for completing a person-centered plan and services authorization. Although the Appellant's Supports Coordinator left voicemail messages with all calls, the Appellant's did not respond. (Exhibits 2, 4, 6).

The Appellant's acknowledged that the made several attempts to schedule an assessment and a person-centered planning meeting. The Appellant's testified that the reason why he did not cooperate with scheduling an assessment is because he needed to better understand what the person-centered planning process was. The Appellant's admitted that he did receive the letter explaining the person-centered planning process, and including the Consumer Handbook, but he wanted more details on what questions would be asked, why those questions would be asked, and how the information was to be used before he agreed to the assessment.

It is unequivocal that the CMH is prohibited from using Medicaid dollars to fund services in the absence of the annual assessment and the current person-centered plan. This Administrative Law Judge is tasked with determining whether the Community Mental Health properly terminated the Appellant's services because there was a months-long gap after the expiration of Appellant's previous person-centered plan with no currently authorized services. Because there is contradictory testimony between the parties this

Administrative Law Judge must weigh the credibility of both parties evidence to reach that determination.

The Appellant bears the burden of proving, by a preponderance of evidence that he made earnest attempts to attend an assessment and person-centered planning process prior to , in , and after. The Appellant's provided no document evidence of attempts to schedule an annual assessment in or after.

The CMH witnesses' testimony was corroborated by each others' testimony and by document evidence and is therefore credible. The Appellant's 's testimony did not offer reason why prior to , and before , he did not inquire about the information he sought in order to agree to the person-centered planning process. In fact, the testimony and document evidence from both parties shows that the reason for canceling or not scheduling an annual assessment prior to , were for other reasons such as needing his to schedule, and not a good time for an assessment. Further evidence of record establishes that the Appellant's and the Appellant's had been Guardians and caregivers of Appellant for more than a decade of CMH services, and have participated as a whole, in several PCP planning processes, therefore the PCP planning process was familiar to the Appellant, the Appellant's , the Appellant's , and the Appellant's family.

It is emphasized that the issue of scheduling difficulty can not override the federal and state mandate that a person-centered plan be in place before services can be authorized and paid for. In other words, no person-centered plan, no Medicaid funds can be used to pay for services. The evidence of record demonstrates the Appellant had no current person-centered plan in place, his mental and physical condition remained stable without services.

The Appellant did not provide a preponderance of evidence that he met the Code of Federal Regulations, the state Mental Health Code, the Medicaid Provider Manual eligibility requirements for Medicaid-covered supports coordination, community living supports, and therapy services. The CMH is bound by the Code of Federal Regulations and the state Mental Health Code in the Medicaid Provider Manual policy. Based on this credible, preponderant evidence, the CMH was proper to terminate Appellant's services on or before , in the absence of any current person-centered plan.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly terminated Appellant's supports coordination, community living supports, and therapy; and authorized medication clinic services.

**IT IS THEREFORE ORDERED** that:

The CMH's decision is AFFIRMED.

______________________________
Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 4/7/2011

***** 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.