STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-25139 CMH
Case No. [redacted]

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 [redacted]. [redacted] appeared without representation. His witness was his sister, [redacted]. [redacted], represented the Department. Her witness was [redacted]

ISSUE

Did the Department properly deny Community Living Supports (CLS) and Support Coordination owing to lack of medical necessity?

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] year-old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is enrolled at [redacted] for outpatient counseling.

3. Appellant and his wife live with Appellant's sister. Appellant's sister is also the 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 wants help handling his money. (Exhibit A, p. 28).

6. Appellant is able to perform his own activities of daily living. (Department's Exhibit A – throughout).

7. Appellant has natural supports, including his sister and sister-in-law.

8. The Appellant's CLS was terminated in [redacted] for lack of medical necessity. He appealed and the decision to terminate was upheld by the ALJ. (Department's Exhibit A, p. 4)

9. Appellant requested community living supports (CLS) from CMH on [redacted], which, following in person assessment, was denied - as not meeting medical necessity criteria. (Department's Exhibit A, pp. 3, 4, 28).

10. Appellant has a mental health history, including mild mental retardation. (Department's Exhibit A, p. 3)

11. Presently, the Appellant receives appropriate outpatient therapy for persistent emotional issues through [redacted]. On in-person assessment it was recommended that those services continue. (Department's Exhibit A, p. 29)

12. Following in-person assessment on [redacted], owing to the Appellant's independence and lack of need - supports coordination was denied for lack of medical necessity. (Department's Exhibit A, pp. 1, 2, 29)

13. The Appellant's request for hearing was received by the Michigan Administrative Hearing System for the Department of Community Health on [redacted]. Appellant's 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 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.

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The CMH [redacted], and [redacted], testified that on in-person assessment the Appellant remained high functioning and independent. He repeated his requests for transportation – although he had access and availability to public transportation and repeated his request for help handling his money. Because these matters are adequately addressed and because the Appellant was thought to

appropriately benefit from continued outpatient counseling – the requests for CLS and supports coordination were denied for lack of medical necessity.

The CMH witness explained that the Appellant knew how to use public transportation to access the community and had natural supports. Accordingly, Medicaid funds could not be used to pay for community living services otherwise available from natural supports. The CMH witnesses said that the Appellant has frequently requested CLS.

The Department's Medicaid Provider Manual (MPM), Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5 explains the criteria utilized to make supports and services decision under the rubric of medical necessity. The MPM states:

> **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. (Emphasis supplied)
>
> MPM, §2.5B, p. 13, April 1, 2011

The Appellant testified that he has a hard time reading and writing and that when he goes out on his own he has trouble – including issues with maintaining his diet. He said that he wants all of his benefits back and that he intends to stand up for his rights.

The Department witnesses acknowledged that part of the Appellant's emotional issue presents as a feeling of betrayal – although he remains polite and respectful to mental health professionals.

The Appellant's sister, in a written closing, lobbied for a "second chance" for her brother.

During the hearing, the CMH introduced policy and records to support its position. The evidence on this record again demonstrated that the Appellant is either able to perform the tasks himself or has natural supports to help him. (See Testimony and Department's Exhibit A, throughout).

The Appellant must prove by a preponderance of evidence that the CMH denial of CLS and supports coordination was in error. The CMH provided credible evidence that its [redacted], denial of supports coordination and CLS following in-person assessment was proper.

As for the sister's request for a second chance the ALJ reminds her that he lacks equitable jurisdiction to provide such remedies.

DECISION AND ORDER

The CMH's denial of Appellant's request for CLS and supports coordination was proper when made.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/10/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.