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. 2011-4156 CMH
Case No. 10248840

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 on behalf of the Appellant. She had no witnesses. [redacted] represented the Department. Her witnesses were: [redacted] and [redacted].

ISSUE

Did the Department properly deny the Appellant's request for 1:1 staffing while attending a vocational program?

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 [redacted] Medicaid, SSI, beneficiary. (Appellant's Exhibit #1)

2. The Appellant is identified as a person with severe MR, cerebral palsy, HTN, petit mal seizure disorder, and disruptive behavior disorder NOS. (Department's Exhibit A, pp. 1, 15, 34 and 39)

3. Currently, the Appellant receives supports coordination, and vocational services through CMH contractor [redacted] She also receives respite and psychiatric evaluation. (Department's Exhibit A, pp. 1 and 16)

4. On [redacted] the parties, and other principals, met and negotiated the Appellant's person centered plan. (Department's Exhibit A, pp. 17–24)

5. A periodic review of the IPOS was conducted on [redacted], where the Appellant was placed on a hiatus from her vocational program while her guardian sought review of her request for 1:1 staffing. Also identified therein was the Appellant's propensity for idiopathic falling, self-injury and potential mini-seizure. (Department's Exhibit A, pp. 32-39)

6. There was no testimony or proof submitted by the Appellant's representative at hearing that the newly observed episodes of falling ["she had been observing Monique for signs of mini-seizures"] had been medically investigated – as recommended by [redacted] on [redacted]. (Department's Exhibit A, p. 39)

7. Between the dates of [redacted] and [redacted] the Appellant sustained zero to minor injury while recreating with her group the result of falling, horseplay and unknown reasons. (Department's Exhibit A, pp. 26, 27, 29-31)

8. On [redacted] the Appellant was dropped off by the [redacted] evening driver at the wrong residence. Following an investigation that [redacted] driver was terminated from employment. (Department's Exhibit A, p. 28)

9. The incident/accidents were reviewed by [redacted] who opined that they were "accidents" and that increased ratio of staffing would not have prevented any of the incidents. (Department's Exhibit A, p. 6)

10. The Appellant was notified of the denial for increased staffing on [redacted]. (Department's Exhibit A, p. 4)

11. The instant appeal was received by the State Office of Administrative Hearings and Rules (SOAHR) on [redacted].

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) HSW. Oakland County Community Mental Health Authority (OCCMHA) contracts with the Michigan Department of Community Health to provide services under the HSW. In turn, MORC and CEO function as contractors for the Authority.
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> ***

Not fully addressed by the parties is the Appellant's right to receive services in the least restrictive manner – and in a safe and sensible manner. Therefore the rhetorical question of how safe is safe takes on real meaning for the parties to this dispute.

The facts establish that a series of minor accidents befell the Appellant. These incidents were investigated, prophylactic measures taken where possible and the Appellant was retuned to

her normal activity. The incident involving dropping the Appellant off at the wrong address was obviously more troubling – but it can not be denied that the Department took definitive action to make sure it never happened again – firing the driver. Should it ever have happened? No. Is it useful to guard the Appellant with a phalanx of attendants: is that the most efficacious use of resources?

WHAT IS THE BEST REMEDY FOR THE APPELLANT?

Clearly, the Appellant's representative is concerned about the safety of her [redacted] while attending the vocational program. At present her options include more staffing [pursued via this appeal] or voluntary removal from the program. The Appellant's representative identified that the Appellant had a [new] spate of unexplained falling and self-injury. It was recommended by the Department that these new symptoms be further investigated. See testimony of [redacted].

There was no proof that this action was taken and thus the Appellant's only concrete avenue to achieve increased staffing owing to medical necessity [based on this record] escaped her legal grasp.

Assuming that there is no further medical difficulty afflicting the Appellant it is not clear to this reviewer that more attendants would be in the Appellant's best interest or enable her to live her life in the least restrictive manner. The extra attendants would no doubt make the Appellant's mother feel better – but it would not necessarily help the Appellant.

Furthermore, placing the Appellant in a less <u>active</u> environment solely for safety strikes the ALJ as something akin to a restraint – absent a known medical complication - is further isolation appropriate?

The Department's testimony and evidence answers the above queries in the negative and with good reason – *under exisiting policy* – existing staffing levels remain the most appropriate and least restrictive means to accomplish the goals of the policy.

In weighing an authorization for increased staffing [redacted] must apply the Department's medical necessity criteria, including the operative standard in effect for this Appellant. The Medicaid Provider Manual (MPM) policy for medical necessity is as follows:

> **[ ] 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.

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Using criteria for medical necessity, a PHIP 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 [ ], Medical Necessity, §§2.5 A, D,
pages 12 – 14, January 1, 2011

Based on policy the Department's action in denying the request for increased staffing was correct when made. However, as always, the individualized need for services memorialized above appreciates the reality that people and their conditions can change – sometimes for the better and sometimes not. The person centered plan is not an inflexible tool.

The evidence presented by the Appellant does not support a conclusion that additional human staffing is medically necessary. It appears that chief among the Appellant's concern is fear of the unknown, which is understandable. However, excessive security often provides no security at all.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the current staffing levels in place for the Appellant are adequate and that the Department's decision to deny additional support was appropriate 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: 3/8/2011

***** 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.