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:

Docket No. 2012-37516 CMH

[redacted],

Appellant

[redacted]/

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], the Appellant's brother/Guardian, appeared on behalf of the Appellant.

[redacted], Hearing Officer, [redacted] County Mental Health Center (CMH), appeared and testified on behalf of the CMH. [redacted] also appeared as witnesses for the [redacted]

ISSUE

Did the CMH properly terminate the Appellant's supports coordination, 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 a [redacted] year-old (DOB: 1/26/1973) Medicaid beneficiary. (Exhibit 3 and testimony).

2. The Appellant has been diagnosed with severe mental retardation and bipolar disorder. (Exhibit 3 and testimony).

3. The Appellant's representative at the hearing was his brother and Co-Plenary Guardian, [redacted]. (Exhibits 5 & 7)

4. In and prior to [redacted] the Appellant was enrolled in and received services from [redacted] Community Mental Health (CMH). The CMH contracts with [redacted] to provide supports coordination and other mental health services for its Medicaid mental health enrollees. (Exhibit 6).

5. In order for Medicaid to pay for mental health services the Medicaid beneficiary must have the current annual [redacted], 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 last [redacted] was completed in [redacted]9 and expired in or around [redacted]. At expiration of his [redacted] the Appellant's CMH services authorization ended. (Exhibits 4, 6)

8. Following numerous efforts by Appellant's Supports Coordinator to obtain a face-to-face psychosocial assessment needed to proceed with the development of a new [redacted] the Appellant's brother/Guardian did not follow through on making the Appellant available for the assessment and Appellant's Medicaid services were terminated, except for medication clinic. Thereafter, on [redacted] the CMH sent an Adequate Action Notice to the Appellant that his supports coordination, community living supports, and therapy would be terminated; and that only medication clinic services would be authorized. The Appellant's brother/Guardian filed a request for hearing on [redacted], and an expedited hearing was held. Following the hearing, Administrative Law Judge Lisa K, Gigliotti issued a Decision and Order dated [redacted] affirming the CMH's decision to terminate Appellant's supports coordination, [redacted], and to authorize [redacted] [redacted] services. Judge Gigliotti found that the Appellant's brother/Guardian's failure to follow through with making the Appellant available for the psychosocial assessment needed to proceed with the development of a new [redacted] prohibited the CMH from authorizing the use of Medicaid to provide services for the Appellant due to the absence of an annual assessment and a current PCP. (Exhibit 6).

9. On [redacted], Appellant's case was "opened" for a supports coordinator only when Appellant's brother/Guardian agreed to schedule a face-to-face psychosocial assessment so they could get started on the development of a new [redacted] However, Appellant's brother/Guardian failed to show for the scheduled appointment, and cancelled another scheduled

for [redacted] Despite Appellant's brother/Guardian's failure to cooperate, Appellant's Supports Coordinator continued to make efforts to get a psychosocial assessment scheduled so they could proceed with developing a new [redacted] and even as recent as [redacted] the Supports Coordinator attempted to schedule the needed assessment, but could only leave a message for Appellant's brother/Guardian who failed to return the Supports Coordinator's call. (Exhibits 3 & 4, and testimony).

10. On [redacted], the Supports Coordinator sent Appellant an Adequate Action Notice indicating the Supports Coordinator was being terminated effective immediately, because there was no current psychosocial assessment or PCP to support the authorization of a Supports Coordinator. (Exhibits 1-2 and testimony).

11. On [redacted], MAHS received Appellant's request for hearing that was filled out by the Appellant's brother/Guardian Maurice Maye. (Exhibit 5).

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 brother/Guardian failed to cooperate in making the Appellant available for the psychosocial assessment needed to determine medical necessity for Medicaid covered services and to go forward with developing a person-centered plan, despite numerous attempts to schedule the assessment. Furthermore, due to the Appellant's brother/Guardian's failure to cooperate, no current PCP was developed and accordingly, the authorization for a Supports Coordinator was properly terminated.

As such, the issue in this case is whether it was proper for the CMH to terminate the Appellant's Supports Coordinator after repeated attempts failed to secure a psychosocial assessment so that a current person-centered plan could be developed?

> 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 Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Program Requirements, Section 2* lists the program requirements for provision of Mental health and developmental disabilities services by the local CMH and/or their contractual providers. This section provides:

> **SECTION 2 – PROGRAM REQUIREMENTS**
>
> **2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES**
>
> Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:
>
> - Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
> - Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
> - Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and the county Department of Human Services [DHS] offices).
> - Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.
- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee. (Underline added).

Medicaid Provider Manual, Mental Health and Substance Abuse, Program Requirements Section, April 1, 2011, p. 8.

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

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, April 1, 2011, page 13.

The CMH representative and the CMH/NSO witnesses testified that CMH/NSO 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's Supports Coordinator should be terminated, and that the Appellant would be continued only for medication clinic.

The testimony of [redacted] two trained and licensed social workers, established that psychosocial assessments must be completed in person or face-to-face in order to render valid results. The witnesses established that it was the standard of practice to conduct such evaluations face-to-face. It is necessary to be able to observe the person being evaluated and to assess their manner of answering questions and their behavior during the assessment in order to get a complete and accurate picture of the individual and their needs. [redacted]' hearing summary further established that such an assessment can be a Medicaid covered service, but must be done face-to-face in order to for it to be covered by Medicaid.

The CMH witnesses' testimony corroborated each other, and was consistent with the documentary evidence admitted during the administrative hearing. As such the CMH witnesses' testimony was credible and established:

- On [redacted], [redacted] contacted [redacted] the Supports Coordinator to schedule a psychosocial assessment. The Supports Coordinator attempted to schedule it for [redacted], at Appellant's home. However, [redacted] stated that he wanted to meet a [redacted] for the assessment. The matter was then scheduled for [redacted]

- On [redacted] [redacted] was a no-call no-show for the scheduled appointment for the psychosocial assessment.

- On [redacted] [redacted] left a message for the Supports Coordinator to reschedule the missed appointment. The Supports Coordinator offered to reschedule the psychosocial for [redacted], but [redacted] declined stating he needed to research the matter and would get back to her.

- On [redacted], the Appellant and his brother/Guardian met with the Supports Coordinator to say they wanted to get an independent facilitator

to attend the meeting who would record the assessment. [redacted] proposed to fax the Supports Coordinator what he expected to have at the meeting. [redacted] was advised that the date and time for the meeting would have to correspond with her schedule.

- On [redacted], the Supports Coordinator contacted [redacted] to schedule the psychosocial assessment for [redacted]. The date for the assessment was confirmed with [redacted]

- On [redacted], [redacted] called to say the psychosocial form would take too long time to complete, that he would fill out the form, but they would have to reschedule the appointment. The Supports Coordinator rescheduled the appointment for [redacted] and this was confirmed with [redacted]

- On [redacted] [redacted] and the Appellant missed the scheduled appointment with the Supports Coordinator for the psychosocial assessment.

- On [redacted] the Supports Coordinator met with the Appellant and his Guardian Maurice Maye as the Appellant was attending a scheduled doctor's appointment. [redacted] stated Appellant was doing fantastic. The Supports Coordinator inquired about scheduling a psychosocial and [redacted] said he would get back to her.

- On [redacted], [redacted] left a message demanding that a [redacted] meeting be scheduled without a psychosocial being done.

- On [redacted] the Supports Coordinator returned the call and left a message for [redacted] that the psychosocial needed to be scheduled first to obtain the information necessary to complete a [redacted] [redacted] did not return the Supports Coordinator's call.

- On [redacted], the Supports Coordinator met with her supervisor [redacted] and it was determined that Appellant's case was to be closed for supports coordination and returned to medication clinic only.

- On [redacted], [redacted] spoke to [redacted] who advised that [redacted] could come out to the home to do a psychosocial assessment.

- On [redacted], the Supports Coordinator called and left a message for [redacted] to schedule an appointment for the psychosocial evaluation, but [redacted] returned the call.

The Appellant's brother/Guardian [redacted] did not dispute the history of contacts established by the CMH witnesses. Rather he stated that no laws, regulations, policies, or manuals had been provided to him regarding the matters cited during the hearing. [redacted] argued that the hearing was not fair because he had not been provided with the laws, regulations, and policies referred to during the hearing. [redacted] acknowledged that this case was essentially the same as the previous case decided by Judge Gigliotti, and it was apparently based on the claim that the psychosocial and the [redacted] needed to be done before services could be authorized.

[redacted] claimed that he had asked [redacted] and the others to provide him with the authority that requires the psychosocial and the [redacted] to be done on an annual basis before Medicaid services can be authorized. [redacted] argued that the proceeding was unfair because he had not been provided with all the evidence that had been used against him.

[redacted] has essentially ignored his own failure to make the Appellant available for the needed assessment, and has attempted to excuse his lack of cooperation by continuing to assert that the CMH and [redacted] have not proven to him that they need to do an in person or face-to face assessment of the Appellant before proceeding with a new [redacted], or that an annual [redacted] is required before the CMH can reauthorize the Medicaid services that were terminated back in [redacted]. Judge Gigliotti's prior decision establishes that the Appellant's brother/Guardian was previously provided with this information, and the Judge's decision affirmed the CMH's position that the services could not be continued without an annual assessment and the development of a new [redacted]

It is clear that the CMH is prohibited from using Medicaid dollars to fund services in the absence of an annual assessment and a current person-centered plan. This Administrative Law Judge must determine whether the Community Mental Health properly terminated the Appellant's Supports Coordinator because of the absence of an annual assessment and a current person-centered plan. This Administrative Law Judge, like the CMH, must follow the Code of Federal Regulations, the state Mental Health Code, and the policy as found in the *Medicaid Provider Manual* when deciding whether Medicaid services should be authorized by the local CMH.

The Appellant bears the burden of proving, by a preponderance of evidence that he made earnest attempts to attend an assessment and follow through with the person-centered planning process prior to the termination of the Supports Coordinator in this case. The Appellant's brother/Guardian/representative provided no evidence of any legitimate attempts to follow through with obtaining an annual assessment for the Appellant at any time. Rather he continued to avoid the efforts to obtain such an assessment and now attempts to make excuses for why it is [redacted] or the CMH's fault that the process has not moved forward. The Appellant's brother/Guardian's statement at the conclusion of the hearing that "there is no problem with doing a psychosocial or a

new [redacted]" rings hollow in light of his own continued efforts to avoid following through with the person-centered planning process.

It is clear that this Administrative Law Judge can not override the federal and state mandate that a person-centered plan be in place before Medicaid services can be authorized. 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. The clear reason for this is that the Appellant's Guardian has failed to cooperate with the person-centered planning process.

This case essentially remains at the same place it did at the time Judge Gigliotti affirmed the CMH's denial of services back in [redacted] But for the limited re-opening of the Appellant's CMH case for Supports Coordinator only, there would be no jurisdiction for the undersigned Administrative Law Judge to even hear this case. The only service the Supports Coordinator was providing was her efforts to schedule the annual assessment needed to follow through with the [redacted] process. Since Appellant's representative has thoroughly demonstrated his unwillingness to follow through with the process, CMH had no alternative but to terminate the Supports Coordinator and return the matter back to medication clinic only.

The Appellant did not provide a preponderance of evidence that he met the Code of Federal Regulations, the state Mental Health Code, or the Medicaid Provider Manual eligibility requirements for Medicaid-covered supports coordination. The CMH/[redacted] is bound by the Code of Federal Regulations, the state Mental Health Code, and the Medicaid Provider Manual policy. Based on this credible, preponderant evidence, it was proper for the CMH to terminate Appellant's Medicaid-covered supports coordination, 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/NSO properly terminated Appellant's supports coordination, and authorized medication clinic services only.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4-26-12

***** 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.