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. 2012-44676 CMH
Case No. [redacted]

Appellant[1]
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] Appellant's [redacted] and legal guardian, appeared and testified on Appellant's behalf. [redacted] Manager of Due Process, appeared on behalf of the Genesee County Community Mental Health (CMH). [redacted] Utilization Manager, also appeared as a witness for the CMH.

ISSUE

Did the CMH properly terminate Appellant's home-based 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 CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area. The CMH also contracts with Easter Seals to provide services. [redacted]

2. Appellant is a [redacted] who has been authorized to receive services through the CMH and Easter Seals, including home-based services. [redacted]

3. However, while home-based services have been authorized, Appellant meets with his worker at school and receives medication reviews through his primary care physician. [redacted]

[1] Initially, Appellant's [redacted] was mistakenly identified as the Appellant in this matter by the Michigan Administrative Hearing System. That error has now been corrected.

4. As testified to by [redacted], home-based services typically include home visits and medication reviews in the home as part of a bundle of services. [redacted]

5. As testified to by Appellant's [redacted] and documented in his progress notes, Appellant has demonstrated improvement in his behavior since he started receiving services. [redacted]

6. On [redacted] a new plan of service was developed for Appellant and home-based services were again requested. [redacted]

7. On [redacted] the CMH sent Appellant notice that it was terminating his home-based services because they were not medically necessary. The effective date of the termination was identified as [redacted] but the CMH also decided that there would be a one month transition period. [redacted]

8. The Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant 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…
>
> (42 USC 1396n(b))

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 of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section, articulates the relevant policy and, with respect to home-based services, it states in part:

> **SECTION 7 – HOME-BASED SERVICES**
>
> Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant

> interventions, parent/youth and professional teamwork, and connection with community resources and supports.
>
> **7.1 PROGRAM APPROVAL**
>
> Medicaid providers seeking to become providers of home-based services must request approval from MDCH through an enrollment process. Once enrolled, a program must re-enroll every three years. (Refer to the Directory Appendix for contact information.) MDCH approval will be based on adherence to the requirements outlined below.
>
> Applications for enrollment must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDCH must include basic program information submitted in a format prescribed by MDCH. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDCH or provisional approval will be withdrawn . . .
>
> (MPM, Mental Health and Substance Abuse Section, January 1, 2012, pages 12-13)

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230. Regarding medical necessity, the MPM provides:

> **2.5.A. 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.

(MPM, Mental Health and Substance Abuse Section, January 1, 2012, pages 12-13)

The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits as medically necessary:

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.

(MPM, Mental Health and Substance Abuse Section, January 1, 2012, page 13)

In this case, Appellant has been previously approved for home-based services. However, despite that approval, it appears that Appellant has not actually been receiving home-based services. For example, as testified to by Appellant's [redacted], Appellant meets with his worker at school and receives medication reviews through his primary care physician. [redacted] Outside of Appellant's [redacted] testimony, the record is silent regarding the services been provided.

Neither the CMH's witness nor Appellant's [redacted] could explain why Appellant was not receiving services in the home as authorized. [redacted] was not personally involved in the provision of services and could only testify that the way Appellant was receiving his services is atypical. [redacted] She also testified that home-based services are expected to be supplied in the beneficiary's home and integrated with what the family is doing. [redacted] Appellant's [redacted] testified that she only did what Easter Seals directed her to do. [redacted]

Nevertheless, as conceded by Appellant's [redacted] and documented in his progress notes, it is undisputed that Appellant has shown improvement in his behavior despite not receiving what was authorized. [redacted] Given that improvement in the absence of receiving home-based services, it appears that home-based services are not medically necessary and Appellant does not require those more intensive services. Moreover, as testified to by [redacted], the services Appellant would receive if his home-based services are terminated would be very similar to what he is receiving now. [redacted]

Appellant has the burden of proving by a preponderance of the evidence that the CMH erred. Here, Appellant has failed to meet that burden. While, through no fault of his own, Appellant has not been receiving the home-based previously approved, he has demonstrated improvement in his behavior and it appears that home-based services are not medically necessary. Accordingly, the CMH's termination of services must be sustained.

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 home-based services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6.11.2012

***** 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.