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) 373-4147

IN THE MATTER OF

[redacted]
Appellant

Docket No. 2013-22559 CMH
Case No. [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], Appellant's sister, appeared and testified on Appellant's behalf. Appellant also appeared but did not testify. Appellant's mother and guardian, [redacted], also appeared but did not testify.

Attorney [redacted], Corporate Counsel for [redacted] County Community Mental Health and Substance Abuse Services (CMH or Department), represented the Department. [redacted], Supports Coordinator Supervisor; [redacted], Supports Coordinator, [redacted], Senior Executive Officer; [redacted], Program Director; and [redacted], Utilization Review Coordinator, [redacted], appeared as witnesses for the Department.

ISSUE

Did CMH properly determine that the only replacement service for Appellant's in-home Community Living Supports (CLS) was the receipt of CLS in a specialized residential setting?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted]. Appellant is diagnosed with Moderate Mental Retardation and Cerebral Palsy. (Exhibit A, pp 4-5; Testimony)

2. Appellant is prescribed the medications Levothyroxine, daily aspirin, folic acid, vitamin D, thickening agents for liquids, and creams to address recurring yeast infections. (Exhibit A, p 6)

3. Appellant resides alone in her own apartment in [redacted] Michigan. Appellant's informal supports include her sisters and mother. Appellant has a significant other whom she sees at least weekly. (Exhibit A, p 5)

4. Appellant has been receiving services through CMH since [redacted]. Appellant had been receiving CLS staffing 24 hours per day, 7 days per week until [redacted], when the services were reduced to 12 hours per day. The decision was upheld following an administrative hearing. (Exhibit A, p 5; Exhibit B; Testimony).

5. Appellant was receiving her in-home CLS services through [redacted] (ROI). On [redacted], ROI provided 30 day notice that it would no longer provide services to Appellant and ROI stopped providing services on [redacted]. Documentation reflected a mutual dissatisfaction between ROI and the family, with accusations of staff stealing, staff sleeping on the job, various relatives of caregivers in Appellant's apartment, as well as accusations of verbal abuse from Appellant and her family towards ROI staff. (Exhibit A, p 12; Testimony)

6. ROI was the last available provider that contracts with CMH to provide in-home services to persons such as Appellant. CMH has attempted to link Appellant with other contracted providers, but those providers either have already been tried and terminated, or have declined to provide services to Appellant. (Exhibit A, p 13)

7. Appellant had a self-determination agreement in the past, but it was terminated due to fraudulent activity. CMH is not willing to enter into another self-determination agreement at this time. Appellant's most recent self-determination agreement with CMH was a Provider with Choice Agreement, which requires that the provider used also have a contract with CMH so that CMH can ensure that the provider is following all Medicaid rules and policies. (Exhibit A, pp 13, 28, 53-56; Testimony)

8. Given that there was no contracted provider available to provide CLS services to Appellant, CMH offered Appellant services through a specialized residential program or a program such as ROI's Azure Home setting. (Exhibit A, p 13)

9. On [redacted], CMH's Senior Executive Officer sent to Appellant's guardian a letter outlining the numerous reasons why CMH would not be agreeable to entering into a self-determination agreement at this time. (Exhibit A, pp 53-55)

10. On [redacted], CMH's Senior Executive Officer sent Appellant a letter outlining the CMH's recommendations for serving Appellant given that there is no longer a contracted provider willing to serve Appellant in her home. CMH's Senior Executive Officer indicated that the most

clinically appropriate setting to serve Appellant would be in a specialized residential home because it would allow for more interaction, socialization, recreation and community inclusion. (Exhibit A, pp 56-57)

11. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (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 Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Lifeways 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.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **2.5 MEDICAL NECESSITY CRITERIA**
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **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.
>
> **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.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP 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.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
April 1, 2013, pp 12-14

CMH's Senior Executive Officer testified that she sent Appellant's family a letter on [redacted] outlining the reasons why CMH would not enter into another self-determination agreement with Appellant at this time. CMH's Senior Executive Officer indicated that there were problems with services not being completed or documented and other issues regarding Appellant's family's ability to supervise Appellant's care workers. CMH's Senior Executive Officer also testified that she sent a letter to Appellant's family on [redacted] indicating that CMH believes that the most appropriate place for Appellant to receive services is in a specialized residential setting, but that if a contracted provider becomes available, the CMH will still allow the provider to serve Appellant in her own home. CMH's Senior Executive Officer indicated that CMH has contacted all contracted providers and none are able or willing to serve Appellant at this time.

A Utilization Review Coordinator from [redacted] (Review Coordinator) testified that she was asked to review Appellant's case. The Review Coordinator indicated that she acts as a separate set of eyes to review actions by the CMH to make sure they are appropriate. The Review Coordinator testified that she conducted a Utilization Management Review of Appellant on [redacted] by reviewing Appellant's clinical records from CMH and [redacted]. The Review Coordinator indicated that she was

aware when conducting the review that [redacted] was no longer providing services to Appellant. The Review Coordinator indicated that while Appellant still met the medical necessity for 12 CLS hours per day, if those services could not be provided in the home, then the best place for Appellant to receive the services would be in a specialized residential setting. The Review Coordinator agreed that Appellant would have more opportunities for community inclusion should she be in a specialized residential setting.

Appellant's sister testified that she was objecting to the denial of a new self-determination agreement because she does have a provider who would be willing to provide services to Appellant in her home, but the provider is not a contractor with CMH. Appellant's sister also testified that she would like a new case manager for Appellant because she believes the current case manager is acting as a barrier to Appellant receiving services.

Appellant's sister was advised by the undersigned that the denial of a self-determination agreement is not an appealable issue because self-determination in and of itself is not a Medicaid covered service; it is simply one way to implement and pay for a service.

Based on the evidence presented, CMH has properly determined that the only replacement service for Appellant's in-home Community Living Supports (CLS) is the receipt of CLS in a specialized residential setting. CMH has sought, and continues to seek, a contracted provider for Appellant to continue to receive services in her home, but until or unless such a provider can be located, Appellant will need to consider receiving services outside of the home.

Appellant was also advised that, even though CMH's denial of a new self-determination agreement is not an appealable issue, she could seek to convince CMH that a self-determination agreement would be manageable now. Appellant could also seek to have the provider of her choice become a contracted provider with CMH.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

> The CMH properly determined that the only currently available replacement service for Appellant's in-home Community Living Supports (CLS) is the receipt of CLS in a specialized residential setting.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: June 14, 2013

Date Mailed: June 14, 2013

***** 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.