STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted] Docket No. 14-018353 CMH

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted], Appellant's father appeared and testified on behalf of the Appellant. Appellant's mother and legal guardian also testified for the Appellant.

Attorney [redacted], Corporate Counsel, appeared on behalf of [redacted] County Community Mental Health Authority (CMH), representing the Department. [redacted] Due Process Manager, was also present for the hearing. [redacted] Case Management Supervisor, [redacted], appeared as a witness for the Department.

ISSUE

Did CMH act properly in their efforts to go forward with the development of a new Individual Plan of Service (IPOS) for the Appellant in this case?

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 was a [redacted]-year-old Medicaid beneficiary (DOB [redacted]) at the time of the hearing. (Exhibit A, pp. 3, 51 and testimony).

2. [redacted] County Community Mental Health Authority (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. On [redacted], Appellant became a client of CMH's contractor [redacted]) after she was discharged from [redacted]. At that time [redacted] was providing Community Living Services in the Appellant's home that included with two-to-one staffing that would provide monitoring, supervision and assistance for the Appellant with her activities of daily living (ADLs). (Exhibit A, pp. 1, 3 and testimony).

4. In [redacted] discontinued services for the Appellant, because the services were declined by Appellant's parents/guardians. (Testimony).

5. On [redacted] [redacted] issued an IPOS Periodic Review that was sent to the Appellant's Guardian stating "Extend engagement goal. CM (Case Manager) has not received signed releases from Guardian to coordinate health care coordination with providers to get any recommendations from their assessments to assist in determining medically necessary services." An Adequate Action Note was also sent advising the Guardian of the Appellant's rights to a local appeal or a Medicaid Fair Hearing. (Exhibit A, pp. 3-14).

6. On [redacted], Appellant's CM with [redacted] completed a Case Management Assessment. In the assessment the CM stated there was a need for the Appellant to participate in assessments in order to determine service needs and the appropriate level of care needed, and participation in the person centered planning process. The CM stated that there was a need for a psychological evaluation of the Appellant and assessments and recommendations from the Appellant's private psychiatrist, and other the Appellant's other doctors and/or medical specialists. The CM stated she was unable to make a comprehensive assessment needed to develop a new IPOS, and that despite numerous attempts, the CM had been unable to get the Appellant's Guardian to sign the necessary releases needed to obtain the required documentation from the Appellant's medical providers. The CM stated the Guardian has also declined releases to prospective care providers for the Appellant. (Exhibit A, pp. 16-26).

7. On [redacted], an IPOS Meeting was held and a proposed IPOS was prepared that could not be implemented because it was based on outdated information that did not reflect the Appellant's current condition or her needs for specialty mental health services. (Exhibit A, pp. 28-40 and testimony).

8. On [redacted], MAHS received the Appellant's Request for Hearing. (Exhibit 2).

9. On [redacted], the CM completed and sent the Appellant's Guardian an IPOS Periodic Review, for the time period of [redacted] through [redacted], in order to make changes to the proposed [redacted] IPOS per the Appellant's Guardian's request. An Adequate Action Note was also sent advising the Guardian of the Appellant's rights to a local appeal or a Medicaid Fair Hearing. (Exhibit A, pp. 54-70, 71-72).

10. In [redacted] County Probate Court Judge [redacted] ordered the Appellant's Guardian to sign releases that CNS needed to obtain the required documentation from the Appellant's medical providers which would allow them to move forward with the development of a new IPOS for the Appellant. The necessary releases were signed by the Appellant's Guardian on [redacted]. (Testimony).

11. On [redacted], a Nursing Assessment of the Appellant was completed for [redacted] by [redacted] R.N. (Exhibit B and testimony).

12. On [redacted], another IPOS Periodic Review was completed by the Appellant's CM. (Exhibit C).

13. On J[redacted] during the administrative hearing the undersigned received Appellant's Exhibit 1, titled "Testimony for [redacted] Medicaid Hearing, [redacted]" which had not been sent to the Respondent, and also received Respondent's Exhibit B, a Nursing Assessment dated [redacted], and Exhibit C, an IPOS Periodic Review dated [redacted], which had not been sent to the Appellant. The parties were ordered to exchange Exhibits 1, B & C with each other, and the record was held open until J[redacted], to allow the parties an opportunity to submit written responses to the exhibits not exchanged prior to the hearing and each party filed timely written responses.

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. Oakland County Community Mental Health Authority (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.

The *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, October 1, 2014 sets forth the requirements for mental health and developmental disabilities services and the determination criteria for the authorization so such services. It states in pertinent part:

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.

* * *

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.

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;

- that are experimental or investigational in nature; or
- that are 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/Substance Abuse*, October 1, 2014, pp. 8, 12-14, emphasis added].

In this case, the witness for CMH, [redacted], Case Management Supervisor at [redacted] stated on [redacted] the Appellant became a client of [redacted] after she was discharged from [redacted]. At that time [redacted] was providing Community Living Services (CLS) in the Appellant's home that included with two-to-one staffing that would provide monitoring, supervision and assistance for the Appellant with her activities of daily living (ADLs). [redacted] stated the Appellant's condition changed over time while she was at home and she was again hospitalized around [redacted]. [redacted] stated the Appellant went into the hospital a couple of times and the last time she was discharged from the hospital she had several medical needs, but as far as [redacted] knew the Appellant was stable psychiatrically.

[redacted]. [redacted] stated [redacted] was not able to get any information and was not able to get details concerning the Appellant's medical condition because her Guardian would not let [redacted] come to the home, and would only allow the Appellant's CM to come into the home for a short period of time. [redacted] stated the Appellant's Guardian would not sign any releases so they could obtain information from the Appellant's home healthcare providers, and her doctors, or her private psychiatrist. The Guardian also would not allow them to get a nursing assessment or a psychological evaluation. [redacted] stated they needed this information to determine what services were medically necessary for the Appellant so they could develop an IPOS to meet her mental health needs. [redacted] stated the Appellant's medical needs and her need for nursing services were out of their scope of coverage.

[redacted] stated [redacted] was not able to obtain the necessary releases until they petitioned the court and went in front of Judge [redacted] and he ordered the Guardian to sign three releases, one for the Appellant's psychiatrist, one for her medical doctor, and one for a psychological evaluation. [redacted] stated they obtained the releases from the Guardian on [redacted]. [redacted] stated that based on a nursing

assessment that was conducted on [redacted], (Exhibit B), and information received from Appellant's private psychiatrist, they were able to make some recommendations on services for the Appellant. Thereafter, an IPOS Periodic Review was done. (Exhibit C). The plan of service contained in the IPOS Periodic Review, subject to further development, provides for [redacted] hours [redacted] days per week of specialized residential high level of care, with one-on-one CLS staffing in the Appellant's home to provide personal care and assistance with her ADLs, pending a determination on the Appellant's request for Adult Home Help Services by DHS.

Appellant's father testified that he believes CMH is required to provide a full spectrum of care for the Appellant including nursing care. He acknowledged that the family requested that the agency providing services to the Appellant [redacted]) be discharged in [redacted]. He said the Appellant then went into the hospital. Appellant's father said they did not provide general releases to [redacted] to obtain information from the Appellant's private mental health and healthcare providers. He said they agreed to get [redacted] whatever information they needed and they did not deny [redacted] access to the Appellant, rather [redacted] never made such a request.

Appellant's father acknowledged that he and the Appellant's mother took over the Appellant's care on [redacted], and they have been providing [redacted] hour care since that time. He said they continued to get requests for releases from [redacted], but asserted that under the law [redacted] could not require them to provide releases as a precondition to them providing care for the Appellant. Appellant's father said [redacted] asked for an assessment from Appellant's private psychiatrist, but what the psychiatrist provided was not satisfactory for [redacted]. He said they also provided information from Appellant's visiting physician, but that was not satisfactory for [redacted]. Appellant's father said that [redacted] did not need access to all of the Appellant's mental health and healthcare providers, and alleged that their requests violated the HIPPA laws.

Appellant's father said that [redacted] wanted them to apply for Home Help Services with DHS and also for the Medicaid Waiver program (MI Choice Waiver program) with the Area Agency on Aging and with [redacted]. He said the waiver agencies both had a [redacted] year waiting list. He said [redacted] would not provide a plan of care until they applied for these other programs. Appellant's father said that [redacted] went to court to get a new guardian appointed for the Appellant who would cooperate with them. Instead, the judge ordered his wife to sign general releases for [redacted] so they could obtain the information they needed at that time to develop a new IPOS for the Appellant. [redacted] concluded by indicating that he believed [redacted] had all the information they needed in [redacted] He said he thought they would be going forward with the IPOS that was being developed in [redacted] and that [redacted] was going to be the Appellant's care provider.

Appellant's mother testified she was the Appellant's legal guardian. Appellant's mother said the Appellant's services were taken away in [redacted] because the provider was not providing proper care, and the family asked to have the provider replaced. Appellant's mother said the Appellant then went into the hospital from [redacted]

for a UTI. Thereafter, the Appellant again went into the hospital in [redacted] Appellant's mother said when the Appellant was discharged from the hospital they were eventually able to put her in a nursing home for rehabilitation in [redacted], that included physical therapy and occupational therapy.

Appellant's mother said she believes that [redacted] is responsible to provide nursing care for the Appellant, but she is not sure what the Appellant's nursing needs are. She also said that [redacted] never asked to do a nursing assessment or a physical health assessment of the Appellant. Appellant's mother said it was her belief if you need an assessment that you just come and do it. She agreed that according to the Mental Health Code CMH is required to conduct such assessments so they are able to determine the appropriate services for a beneficiary. Appellant's mother said she believes [redacted] had all the information they needed from the Appellant's care providers to complete a plan of care when she was discharged from the hospital. She claimed that [redacted] was just engaging in a ruse to not have to serve the Appellant. Appellant's mother said [redacted] refused to serve the Appellant for over seven months. Appellant's mother acknowledged that the Appellant's condition had gotten worse or deteriorated after the Appellant's provider was discharged in [redacted].

The Appellant bears the burden of proving by a preponderance of the evidence that CMH acted improperly by not coming up with a new plan of service for the Appellant after the family asked to have the Appellant's provider discharged in [redacted]. Based upon the totality of the evidence presented in this case, I find that CMH, and in particular their contract provider [redacted], acted properly in their attempts to develop a proper plan of service for the Appellant for the specialty mental health services that may be provided through CMH.

The policy quoted above states that the determination of a medically necessary support, service or treatment must be based on information provided by the beneficiary, the beneficiary's family, and 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, based on person-centered planning; and made by appropriately trained mental health professionals with sufficient clinical experience; and the services must be sufficient in amount, scope and duration to reasonably achieve its/their purpose.

It is clear from the testimony and evidence presented by CMH in this case that the inability to move forward with a new IPOS was caused by the Appellant's parents and/or Guardian's refusal to cooperate with [redacted] efforts to gain the necessary information, as contemplated by Medicaid policy, for developing an IPOS that would provide services in amount, scope and duration to reasonably achieve their purpose of serving the needs of the Appellant for specialty mental health services. Policy also requires that such services are to be coordinated with other community agencies, including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, and the county Department of Human Services.

Accordingly, [redacted]s urging that the Appellant apply for Home Help Services and waiver services through the [redacted] and [redacted] was just in keeping with Medicaid policy.

Despite the testimony of the Appellant's parents to the contrary, I find that [redacted] acted properly in attempting to move forward with the development of a new IPOS for the Appellant, but were thwarted by the parent's actions in not providing the necessary releases so the needed assessments and medical information from the Appellant's mental health and healthcare providers could be obtained. It is quite clear that [redacted] had to resort to petitioning the Probate Court for a new guardian for the Appellant, and that the Probate Judge had to order the Appellant's mother to sign three releases, one for the Appellant's psychiatrist, one for her medical doctor, and one for a psychological evaluation, in order for [redacted] to get the information needed to move ahead with a new IPOS for the Appellant. Contrary to the Appellant's mother's claim that this was all a ruse to keep from serving the Appellant, it is clear that [redacted] would not have resorted to petitioning the Probate Court for a new guardian for the Appellant if they did not have the best interests of the Appellant in mind.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that CMH acted properly in their efforts to go forward with the development of a new Individual Plan of Service (IPOS) for the Appellant in this case.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed [redacted]

WDB/db

cc: [redacted]

***** 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.