STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
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(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-020330 CMH
Case No. [redacted]

Appellant
_____/

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, an in-person hearing was held on [redacted]. [redacted], mother, represented the Appellant. [redacted], CEO and Founder of the [redacted] Organization, and [redacted], Appellant's sister, appeared as witnesses for the Appellant.

[redacted], Assistant Corporation Counsel, [redacted] Community Mental Health ("CMH" or "Department"). [redacted], Program Supervisor with Specialized Children and Family Services ("Program Supervisor") appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny the Appellant's application for wraparound services through the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver ("SED waiver")?

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 male who was diagnosed with attention-deficit/hyperactivity disorder, hyperactive or combined; oppositional defiant disorder; and reactive attachment disorder of infancy or early childhood per a [redacted], Annual Assessment and a [redacted], psychiatric evaluation. (Appellant Exhibit A; CMH Exhibit C)

2. Appellant was a recipient of several types of supports and services, including wraparound services, through another CMH provider agency when the request for wraparound services through the SED waiver was

received by this CMH agency in mid to late [redacted]. (Program Supervisor Testimony)

3. On [redacted], Appellant's request for wraparound services was denied because "consumer does not meet criteria for services requested." (CMH Exhibit A)

4. On [redacted], a request for hearing was filed on Appellant's behalf contesting the CMH determination.

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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Health and Human Services 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**
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> 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; and

- 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;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- 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;

- 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 Chapter
April 1, 2015, pp. 12-14

Regarding Wraparound Services the Medicaid Provider Manual states:

3.29 WRAPAROUND SERVICES FOR CHILDREN AND ADOLESCENTS

Wraparound services for children and adolescents is a highly individualized planning process facilitated by specialized supports coordinators.

Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services and other community services and supports.

The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound.

Children/youth and families served in Wraparound shall meet two or more of the following criteria:

- Children/youth who are involved in multiple child/youth serving systems.
- Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children/youth who have been served through other mental health services with minimal improvement in functioning.
- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are serving multiple children/youth in a family and the identified outcomes are not being met.

> Children/youth receiving Wraparound would not also receive, at the same time, the Supports Coordination coverage or the state plan coverage Targeted Case Management. In addition, PIHPs shall not pay for the case management function provided through home-based services and Wraparound at the same time.
>
> Medicaid providers delivering Wraparound services (provided either as a 1915(b) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service or an SEDW service) must request approval to provide Wraparound from MDCH through an enrollment process defined by MDCH, and re-enrollment must occur every three years. Programs are to be re-enrolled to ensure policy and Wraparound model fidelity adherence.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Section,*
> *April 1, 2015, pp. 23-24*

There is no jurisdiction to address many of the issues raised by Appellant's mother. For example, there is no authority for this ALJ to issue any order(s) regarding CMH eligibility and/or services while Appellant is in a residential setting or for any future potential CMH eligibility and/or services after Appellant leaves the residential setting. For the present case, there is only jurisdiction to address the [redacted], CMH determination to deny Appellant's application for wraparound services through the SED waiver.

The Program Supervisor credibly testified that when the request for wraparound services through the SED waiver was received by this CMH agency in mid to late [redacted], Appellant was already recipient of several supports and services, including wraparound services, through another CMH provider agency. The Program Supervisor confirmed that the SED waiver would have offered the same types of services that were were already available to Appellant through the other CMH agency. Additionally, it was confirmed that an individual cannot receive wraparound services from two agencies at the same time. Accordingly, this request for wraparound services through the SED waiver was denied. (Program Supervisor Testimony)

Appellant's mother provided testimony regarding Appellant's history as well as the more recent behaviors and issues. Appellant's mother testified that she made this request for wraparound services through the SED waiver, on [redacted]. Appellant's mother contested the accuracy of the CAFAS score of 60 considered in the [redacted], Annual Assessment. (See CMH Exhibit C) Lastly, Appellant's mother noted the CMH agency's responsibilities as set forth in documents including the Medicaid Provider Manual and a contract. (Mother Testimony) Appellant's sister also testified that Appellant has really severe problems and noted that past years of therapy did nothing. (Sister Testimony)

The Appellant has the burden of demonstrating by a preponderance of the evidence that Respondent erred in denying the request for wraparound services through the SED waiver. In this case, the Appellant has failed to meet that burden of proof. While, the SED waiver is a different funding source, it offers the same types of services that were already available to Appellant through the other CMH agency that was already providing services. Specifically, the Program Supervisor credibly testified that Appellant was already receiving wraparound services through another CMH agency when this request for wraparound services through the SED waiver was made. Therefore, Appellant had other resources available to provide the requested wraparound services. There is no need to address the accuracy of the CAFAS score of 60 because Appellant could not have received the requested wraparound services from a second agency no matter what his CAFAS score was. The available information supports the CMH determination to deny Appellant's request for wraparound services through the SED waiver.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request for wraparound services through the SED waiver.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: December 30, 2015

Date Mailed: December 30, 2015

CL[redacted]

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.