RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: July 7, 2017
MAHS Docket No.: 17-005835
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 7, 2017. Petitioner appeared and testified on his own behalf. [redacted], Manager of Due Process at the Region 10 PIHP, represented the Respondent [redacted]). [redacted], Supervisor of Adult Case Management, and [redacted], Utilization Management Clinical Coordinator, testified as witnesses for Respondent. [redacted], Manager of Utilization Management, was also present for the hearing, but did not otherwise participate.

Petitioner did not submit any exhibits during the hearing. Respondent submitted one exhibit/evidence packet that was admitted into the record as Exhibit A, pages 1-42.

ISSUE

Did Respondent properly decide to terminate Petitioner's 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. Respondent [redacted] is a Community Mental Health Services Program (CMHSP) affiliated with a Prepaid Inpatient Health Plan (PIHP), the Region 10 PIHP.

2. In the past, Petitioner had recurring symptoms of paranoia, delusions, auditory hallucinations and depression, and he has been receiving services from Respondent since at least 2012. (Exhibit A, page 15),

3. Since January of 2014, Petitioner has also been enrolled in a Medicaid Health Plan (MHP). (Exhibit A, page 15).

4. Assessments or Progress Notes completed with respect to Petitioner's case on March 4, 2015, September 14, 2016, October 17, 2016, and November 14, 2016, all indicated that Petitioner was stable. (Exhibit A, pages 15-25).

5. The Progress Note for October 17, 2016 also provided that Petitioner's supports coordinator had filled out a form regarding Petitioner for the Social Security Administration (SSA) because the SSA wanted the form completed by someone other than Petitioner. (Exhibit A, page 20).

6. Petitioner was to mail the form. (Exhibit A, page 20).

7. On November 16, 2017, an Individual Plan of Service (IPOS) meeting was held with respect to Petitioner's services for the upcoming plan year, *i.e.* December 16, 2016 to December 4, 2017. (Exhibit A, pages 4-9).

8. The sole goal of the IPOS was for Petitioner to maintain a healthy and safe lifestyle and both supports coordination and medication review services were to be authorized in support of that goal. (Exhibit A, pages 6, 9).

9. The IPOS also noted that Petitioner has a primary care physician and he keeps routine appointments with that physician. (Exhibit A, page 6).

10. Subsequent Progress Notes and Quarterly Reviews completed on [redacted], [redacted], [redacted], and [redacted], continued to provide that Petitioner was stable and that he did not have any symptoms of depression, paranoia, agitation, and hearing voices. (Exhibit A, pages 10-14, 26-34).

11. The Progress Note completed on [redacted] also stated that Petitioner had chosen to drop services with neurologist and that his primary care physician would assist him until he got a new one. (Exhibit A, page 32).

12. Petitioner later found another neurologist on his own. (Testimony of Petitioner).

13. On [redacted], the [redacted] sent Petitioner written notice that his supports coordination and medication review services would be terminated as of May 8, 2017. (Exhibit A, pages 1-3).

14. The reason for the termination given in that notice was: "you no longer meet medical necessity for services. Please coordinate with your case manager for assistance in transitioning psychiatric care to another provider." (Exhibit A, page 1).

15. On May 8, 2017, the Michigan Administrative Hearing System received the request for hearing filed in this matter with respect to that decision.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Eligibility for services through Respondent is set by policy as outlined in the Medicaid Provider Manual (MPM). With respect to the specific services at issue in this case, the applicable version of the MPM states:

> **3.17 MEDICATION REVIEW**
>
> Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.
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> * * *
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> **17.3.K. SUPPORT AND SERVICE COORDINATION**
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> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or

otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

However, while medication reviews and supports coordination are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

> **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;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- 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; 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

  - 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.

MPM, April 1, 2017 version
Behavioral Health and Intellectual and Developmental Disability Support and Services
Pages 13-14

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as supports coordination:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.
>
> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
>
> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least

restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College

	Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior

	center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have

> needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service . . .
>
> *MPM, April 1, 2017 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *Pages 125-126*

Here, Respondent terminated Petitioner's supports coordination and medication reviews on the basis that neither services were medically necessary.

In support of that decision, Respondent's Supervisor of Adult Case Management testified that Petitioner's supports coordination services are reviewed quarterly and the reviews in his case have shown that such services are not medically necessary as he has been stable on his medications for over two years and there has been no linking or coordinating of services beyond Petitioner's medication services. She also testified that Petitioner still needs medication services, but that he can get them elsewhere through his MHP and medical providers.

Respondent's Utilization Management Clinical Coordinator similarly testified that Petitioner has not used much time for his supports coordination services and it is mainly just a check in. She also testified that Petitioner is stable and has not had any crisis services in over ten years. She further testified that Petitioner's case can be transferred to another agency for assistance with his medications and it is not medically necessary that he receive them through Respondent.

In response, Petitioner testified that he would like to continue with his services as they have helped him in the past and he wants to pay close attention to his health, with all the help he can get. Petitioner also testified that his supports coordinator has helped him by completing paperwork and talking about his daily activities. Petitioner further

testified that he needs paperwork completed once or twice a year. He also confirmed that, as indicated in the progress notes, he stopped services with one neurologist and found another neurologist on his own.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in terminating his services. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time it made that decision.

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed. Petitioner was only receiving supports coordination and medication reviews through Respondent and neither appear to be necessary at this time. As provided in the MPM, Respondent may deny services where there exists another appropriate and cost-effective service that meets a beneficiary's needs and it is undisputed in this case that Petitioner can receive medication reviews elsewhere through his MHP. Moreover, with respect to supports coordination services, the undersigned Administrative Law Judge agrees with Respondent's determination that Petitioner does not need such services given his undisputed stability and the lack of utilization. At most, Petitioner used the supports coordinator to complete some paperwork, but it is not clear that such assistance was even necessary and Petitioner has demonstrated an ability to link to medical services on his own.

Accordingly, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proving by a preponderance of the evidence that Respondent erred in terminating his services and that Respondent's decision must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly decided to terminate Petitioner's services.

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/db

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS Department Rep. [redacted]

DHHS -Dept Contact [redacted]

Petitioner [redacted]