[redacted]
[redacted], MI [redacted]

Date Mailed: May 5, 2022
MOAHR Docket No.: 22-000685
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 April 7, 2022. [redacted], Petitioner's niece and legal guardian, appeared and testified on Petitioner's behalf. Anthony Holston, Assistant Vice-President of Grievance and Appeals at Beacon Health Options, represented the Respondent Lakeshore Regional Entity. Dr. Scott Monteith, Medical Director at Beacon Health Options, and Millie Russell-Emery, Supports Coordination Supervisor at Network 180, testified as witnesses for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-193. No other proposed exhibits were submitted.

ISSUE

Did Respondent properly terminate Petitioner's supports coordination 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. Petitioner is a [redacted] year-old Medicaid beneficiary who has been diagnosed with moderate intellectual disability and generalized anxiety disorder. (Exhibit A, pages 52, 112).

2. He has a legal guardian and is unable to live independently. (Exhibit A, pages 52, 190).

3. Due to his diagnoses and accompanying functional limitations, Petitioner has also been authorized for services through Respondent, a Prepaid Inpatient Health Plan (PIHP), and Network 180, a Community Mental

Health Service Provider (CMHSP) associated with Respondent. (Testimony of Supports Coordination Supervisor).

4. Petitioner's services through Respondent and Network 180 included supports coordination services and Community Living Supports (CLS). (Exhibit A, pages 85, 156-157; Testimony of Petitioner's representative; Testimony of Supports Coordination Supervisor).

5. Petitioner's CLS was provided both at Victory Palace II, the Adult Foster Care (AFC) home where he lived, and Hope Network, a life skills program in the community. (Exhibit A, pages 49, 85, 156-157, 161; Testimony of Petitioner's representative; Testimony of Supports Coordination Supervisor).

6. Petitioner's AFC home subsequently lost its contract with Network 180, and it was no longer able to provide CLS to Petitioner. (Exhibit A, pages 52, 85, 161; Testimony of Petitioner's representative).

7. In November of 2019, Petitioner enrolled in the MI Choice Waiver Program. (Testimony of Supports Coordination Supervisor).

8. Through MI Choice, Petitioner was able to maintain his housing arrangement and receive personal care services in the AFC home. (Exhibit A, pages 52, 57, 81; Testimony of Petitioner's representative).

9. Petitioner was also approved for case management/supports coordination services through MI Choice. (Exhibit A, page 52; Testimony of Supports Coordination Supervisor).

10. In March of 2020, Petitioner's services at Hope Network stopped after Hope Network closed its program due to the COVID-19 pandemic. (Exhibit A, pages 30, 52).

11. Once Hope Network reopened the program, Petitioner and Network 180 explored the possibility of him returning, but he was unable to do so because of requirements from Hope Network that he wear a mask, which he is unable to do, and/or get vaccinated for COVID-19, which his guardian decided against. (Exhibit A, pages 30, 52, 73-74, 85, 102-104, 126-129; Testimony of Petitioner's representative; Testimony of Supports Coordination Supervisor).

12. The authorization for services at Hope Network also expired on December 31, 2020. (Testimony of Supports Coordination Supervisor).

13. Petitioner and Network 180 further discussed other potential CLS providers, but none were found acceptable, and Petitioner was primarily interested in returning to Hope Network. (Exhibit A, page 131; Testimony

of Petitioner's representative; Testimony of Supports Coordination Supervisor).

14. Petitioner continued to be approved for supports coordination services through Respondent, but Network 180 indicated in March of 2021 and later that it was looking to terminate that service, and close Petitioner's case because Petitioner was getting such services through the MI Choice program. (Exhibit A, pages 79, 102-104; Testimony of Petitioner's representative; Testimony of Supports Coordination Supervisor).

15. Petitioner's guardian indicated in subsequent discussions over the next few months that Petitioner's services through MI Choice were not duplicative of his supports coordination services through Respondent, but she also refused to sign a consent allowing Network 180 to speak with the waiver agency, and she cancelled a meeting with both agencies. (Exhibit A, pages 30, 36-39, 42, 73, 77, 79, 122-123, 125-126, 134-135, 137-138; Testimony of Petitioner's representative; Testimony of Supports Coordination Supervisor).

16. On September 16, 2021, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that his supports coordination services would be terminated as of September 28, 2021 because he had other resources, a community provider agency, available for the service. (Exhibit A, pages 26-29).

17. On September 27, 2021, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, pages 5-8).

18. The Internal Appeal was reviewed by Beacon Health Options, an agency Respondent contracts with. (Exhibit A, pages 166-169).

19. On October 27, 2021, Respondent sent Petitioner written notice that the Internal Appeal had been denied. (Exhibit A, pages 170-184).

20. With respect to the reason for the denial, the notice stated:

> We denied your appeal for the service/item listed above because: You are a 66-year-old male who requested supports coordination (SC) services through the standard Medicaid program managed by Network 180 from 09/28/2021 onward. You currently receive services from the MI Choice Waiver program. You have not utilized SC services with Network 180 for more than 17 months. In addition, there was no specific documentation provided to validate you require these services, and whether the requested SC services might

> duplicate services currently provided through the MI Choice Waiver program. On 09/28/2021, the requested SC services through the Medicaid program managed by Network 180 could not be validated as medically necessary. Your care could have been safely addressed with outpatient mental health services.

Exhibit A, page 170

21. On March 1, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner's guardian in this matter. (Exhibit A, pages 185-190).

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)) (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).

Here, as discussed above, Petitioner has been receiving supports coordination services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.3.K. SUPPORT AND SERVICE COORDINATION**
>
> 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.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker

to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored

- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordinators are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

MPM, July 1, 2021 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 151-153

Moreover, while supports coordination is a covered service, 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

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, July 1, 2021 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 14-16

Here, as discussed above, Respondent decided to terminate Petitioner's supports coordination services pursuant to the above policies.

In support of the action, the Supports Coordination Supervisor at Network 180 testified that, while Petitioner does benefit and qualify for supports coordination, the service can be provided by the waiver agency he is enrolled with and Respondent, as the payor of last resort, therefore cannot duplicate the service. She also testified that Network 180 tried to coordinate with the waiver agency to see if it could provide supports

coordination without duplicating services provided elsewhere, but that they were unable to do so because Petitioner's guardian prohibited it from speaking to the waiver agency.

The Medical Director at Beacon Health Options similarly testified regarding the basis for the action in this case and the review of the Internal Appeal.

In response, Petitioner's guardian/representative testified that Petitioner requires the services he was receiving in 2019, which include CLS, skill building and supports coordination, as those services only stopped due to the COVID-19 pandemic and there is no proof that they are no longer medically necessary. She also testified that Petitioner had those services for years handled by Network 180, and that, while Petitioner had to go on the MI Choice waiver in order to maintain his living arrangement, they wanted those services, and others, through Respondent. She further testified that Network 180 is improperly trying to push them out.

Regarding specific services, Petitioner's guardian testified that there is no duplication between the supports coordination services Petitioner receives through MI Choice and Respondent, as each agency is just handling its own services. She also testified that the waiver agency services do not help, teach or train Petitioner like the CLS he was receiving through Respondent. She further testified that while Petitioner has been unable to attend programming at Hope Network because he is unable to wear a mask; and that masks and vaccines are medical issues that should be determined by Petitioner's doctors.

Regarding changes since the request for hearing was filed in this case, Petitioner's guardian testified that Petitioner was hospitalized in December of 2021; he is currently in a rehabilitation facility; and he is now without a home.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in terminating his supports coordination 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 the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner was approved for supports coordination services through Respondent in the past, but that alone does not mean that the service should continue to be approved and the record in this case reflects that supports coordination services are no longer medically necessary.

As provided above, policy states that, using criteria for medical necessity, Respondent may deny services for which there exists another appropriate and efficacious service that otherwise satisfies the standards for medical necessity; and, in this case, Petitioner has also been approved for supports coordination services through the MI Choice

Waiver program. Moreover, while Petitioner's guardian asserts that the services would not be duplicative of each other, her testimony is unsupported and she has prohibited the appropriate coordination of services that could establish that services do not duplicate each other.

Additionally, as noted by Respondent, Petitioner's supports coordination services are his only current service through Respondent and, while Petitioner's services at Hope Network were previously approved and remain medically necessary, but they stopped due to the COVID-19 pandemic; Petitioner cannot restart them due to the provider's rules and his inability to wear a mask; and Petitioner has nothing to authorize or coordinate given Petitioner only wants services there.

Petitioner's guardian described changes in Petitioner's circumstances since the decision at issue in this case was made and, to the extent Petitioner has additional or updated information regarding his need for supports coordination services, he can always request such services again in the future. With respect to the issue in this case however, Respondent's decision must be affirmed given the available record and applicable polices.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

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

Steven Kibit

Steven Kibit
Administrative Law Judge

SK:tem

NOTICE OF APPEAL: Petitioner 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS-Location Contact

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