STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant

_____/

Docket No. 2011-48460 CMH
Case No. 39476455

DECISION AND ORDER

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

After due notice, a hearing was held on Wednesday, [redacted]. Attorney [redacted] represented the Appellant. Appellant's parents, [redacted] and [redacted], appeared and testified on Appellant's behalf.

Attorney [redacted] represented the [redacted] County Community Mental Health Authority (CMH). [redacted], Family Services Director, [redacted] Living Services, Inc. and [redacted], case worker, appeared as witnesses for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for residential placement?

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 an [redacted] year old Medicaid beneficiary, born [redacted], receiving services through [redacted] County Community Mental Health (CMH) under the Children's Home and Community Based Waiver. (Exhibit A, p 14)

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. The Appellant was diagnosed with autism at the age of [redacted] months. (Exhibit A, p 4). Appellant also has diagnoses of anxiety disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, obsessive compulsive disorder. (Exhibit I, tab R)

4. The Appellant has Blue Cross Blue Shield and Great Lakes Health Plan Medicaid HMO medical insurance. (Exhibit A, p 5)

5. The Appellant lives at home with his parent's and five other siblings, one of which also is diagnosed with autism. (Testimony)

6. The Appellant was hospitalized at [redacted] Psychiatric Inpatient Unit in [redacted], [redacted], and [redacted], and at [redacted] Psychiatric Unit during July 2011. (Exhibit V).

7. The Appellant last attended the [redacted] School for Students with Autism in [redacted], Michigan. (Exhibit III, tab G). Appellant is currently not in school. (Testimony)

8. The Appellant has been receiving services through [redacted] Living Services, Inc. since [redacted]. Current authorized services include: psychiatric evaluations, medication review, case management, respite care (96 hours per month), and community living supports (10 hours per day). (Exhibit A, pp 4-6).

9. On or about [redacted], Appellant's parents requested residential placement for Appellant due to his self injurious behaviors. (Exhibit A, p 9)

10. CMH denied the request for residential placement because it determined that such placement was not medically necessary and that Appellant's needs could be met in a less restrictive environment. (Exhibit A, p 12)

11. On [redacted], the CMH sent a notice to the Appellant's parents notifying them that their request for residential placement was denied. (Exhibit A, pp 10-17). A Request for Hearing was completed by Appellant's attorney on [redacted]. (Exhibit A, p 2)

12. The Tribunal received Appellant's request for hearing on [redacted]. (Exhibit A, pp 1-2)

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

[redacted], Family Services Director at [redacted] Living Services, Inc., the contractor providing services for Appellant, testified that, in her opinion, long term residential placement is not a covered service under the Children's Waiver per both the Medicaid Provider Manual and

the Children's Waiver Technical Assistance Manual. Ms. [redacted] indicated that long term residential placement is not a philosophy of the Agency, a philosophy of Medicaid or the Children's Waiver. Ms. [redacted] testified that she believed maintaining the Appellant in the family home was the most appropriate setting and that the Agency has been providing extensive and intensive services to meet that goal. Specifically, the Agency is providing psychiatric services, case management, and extended stays in a psychiatric hospital if Appellant's private insurance does not cover same. The Agency is also providing 10 hours per day of community living supports and 96 hours per month of respite and has offered the services of an autism specialist and environmental modifications to the home. Since the request for residential placement, the Agency has also offered services through the Center for [redacted]. Ms. [redacted] also testified that the least restrictive setting for Appellant was in his own home and that one of the clinical justification for denying Appellant's request for long term residential treatment was the fact that the hospital released him from their care. In other words, if Appellant was still demonstrating the clinical symptoms that led to his hospitalization in the first place, he would not have been released. Ms. [redacted] testified that she believes that the services provided are appropriate in scope, duration, and intensity to achieve the purpose of the services and that those services can be increased upon approval by MDCH. Ms. [redacted] testified that the Agency has not yet developed its own behavioral plan, but has been relying on a behavioral plan developed by the prior Agency that served Appellant.

[redacted], Appellant's case manager, testified that she has been working with Appellant since [redacted]. Ms. [redacted] testified Appellant's parents have placed no barriers to the services provided by the Agency. Ms. [redacted] also testified that she was at the Appellant's home when 911 had to be called in order to subdue Appellant. According to Ms [redacted], it took three police officers to get Appellant under control.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Sections 2.5.C and 2.5.D provide*:

> **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. (Emphasis added)

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, Program Requirements Section, July 1, 2011, pages 13-14.

[redacted], Appellant's mother testified that in-home services through [redacted] Living Services, Inc. began in [redacted] and that before the school year ended the CLS hours were only used sporadically because workers sometimes did not show up and it was difficult to find staff to work with the Appellant because of his behaviors. Mrs. [redacted] also testified that Appellant's behaviors are consistently self-injurious; that he hits himself in the head repeatedly while screaming, and scratches himself until he bleeds. Mrs. [redacted] testified that Appellant has been hospitalized three times this summer due to his self injurious behaviors and that he is worsening by the day. She reported that Appellant is aggressive towards others, especially towards the family's [redacted] year old, and that his behaviors have had a profound effect on the other children in the household. (The [redacted]'s have a total of six children, five of which are still in the home, and one of which also has autism and is covered by the Children's Waiver). Mrs. [redacted] testified that, in her opinion, the CLS workers in her home do not have the expertise to deal with Appellant and that while she would like to maintain Appellant in the home, it is simply not the right setting for him. Mrs. [redacted] also testified regarding the following specific incidents:

- On [redacted], Appellant had to have both hands placed in casts because he had bitten both thumbs down to the tendons. (Exhibit I, tab J)

- On [redacted], while at bike camp, Appellant became increasing agitated at [redacted], his bike coach. Appellant grabbed [redacted], scratching her neck and upper chest, breaking the skin and causing the area to bleed. (Exhibit I, tab G). Also on [redacted], while returning from bike camp, Appellant began aggressively attacking his respite care worker in the car by attempting to bite and scratch him repeatedly. (Exhibit I, tab F).

- On [redacted], Appellant became agitated while at the pool and attached his CLS worker by scratching his arms and hands. Appellant also bit the worker on his right arm, hand and chest area. (Exhibit I, tab D). Also on [redacted], Appellant bit [redacted]'s right forearm during circle time. (Exhibit I, tab E).

- On [redacted], Appellant was engaging in self-injurious behaviors (hitting self in head, face, picking at open sore on face, resulting in facial bleeding) to the extent that Appellant's father took him to the emergency room. Appellant was transferred to [redacted] Psychiatric Hospital and admitted. (Exhibit I, tab C).

Evidence introduced at the hearing includes the following:

- On [redacted], [redacted], MD, authored a To Whom it May Concern letter in which he opined: "I strongly recommend that [Appellant] be placed in a specialized residential treatment facility where [he] can get one on one attention and behavioral management." (Exhibit III, tab I)

- Also on [redacted], Dr. [redacted], Pediatric Clinic, P.C, who has treated Appellant since his birth, opined: "I have recommended to Mr. and [redacted] that they seek residential placement for [redacted] so that he can receive the expert treatment that he needs." (Exhibit III, tab J)

- On [redacted], following an admission to the Child and Adolescent Psychiatric Hospital at the [redacted] from [redacted] to [redacted], Dr. [redacted] opined: "While medications may provide a modicum of relief, it was the opinion of the team that an airtight behavior plan was critical for any chance of success. We recommended, at the least, an in-home assistant to aid in maintaining the structure we started. Ideally, [Appellant] could benefit from longer term behavioral programming, as in a residential treatment facility." (Exhibit III, tab L)

- On [redacted], Dr. [redacted], Developmental and Behavioral Pediatrician at [redacted] for Developmental and Behavioral Pediatrics, opined: "Given the chronicity and severity of [Appellant's] behavioral difficulties, failure of medications to correct his problems and his current difficulty of the school program to manage his misbehavior, it is my opinion that [Appellant] should be placed in a more

structured, intensified and experienced educational setting, namely, a residential facility that can provide an intensive behavioral intervention program." (Exhibit III, tab K)

- In [redacted], Appellant underwent a reevaluation at the [redacted] Autism and Communication Disorders Center [redacted]ACC) because of his parent's concerns about his lack of academic process as well as his continued physical aggression towards others. The evaluation included testing, interviews, and a school observation. In conclusion, the authors of the report concluded, "To ensure the provision of appropriate services and to ensure [Appellant's] safety, as well as the safety of those around him, we recommend consideration of a residential placement designed to meet the needs of individuals with significant developmental disabilities." (Exhibit III, tab G)

- On [redacted], Dr. [redacted], opined that Appellant is in need of "supervised one-on-one care, and he cannot be safely or properly maintained in the home or at school. He should be placed in a structured twenty-four hour a day residential treatment behavior program that caters to an ABA model of learning." (Exhibit III, tab A1). Dr. [redacted] has been treating Appellant since he was two years old.

- On [redacted], Dr. [redacted], opined that Appellant needs, "A supervised one-on-one residential treatment facility . . ." (Exhibit V, tab C)

Under the Department's medical necessity criteria section, there exists a more clinically appropriate, less restrictive and more integrated setting in the community for Appellant, specifically his own home. Clearly, Appellant's placement in his own home is less restrictive than any residential placement. Furthermore, as noted above, "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." Here, Appellant has only been receiving services in his home since [redacted], and while there have clearly been many difficulties, it cannot be said at this time that this less restrictive level of treatment has been unsuccessful. It is likely that Appellant will require increased services, especially if he is not in school, and should benefit from the development of a behavioral plan. Likely, Appellant will require the approval of 24 hour per day/7 day per week community living supports in the home.

Furthermore, based on the Department's covered services policy, Section 14 of the Medicaid Provider Manual, long-term residential placement is not a Medicaid covered service under the Children's Waiver. Additionally, long-term residential placement is not a covered service under the Children's Waiver Technical Assistance Manual and it does not appear as a covered service on the Children's Waiver application. And while Appellant correctly points out that Children's Waiver services are simply an enhancement to regular Medicaid services, which contemplate inpatient services, those services cannot be provided to Appellant at this time through the Children's Waiver because, as discussed above, Appellant does not meet the medical necessity criteria for residential placement.

Finally, this Administrative Law Judge must base his decision on information the Department had on hand when the denial of long-term residential placement was made. Hence, information provided by the Appellant after [redacted], and events occurring after that date, such as subsequent hospitalizations, cannot be a basis for the decision in this matter. The Agency, of course, is free to consider that information and revisit their denial at any time.

The Appellant bears the burden of proving by a preponderance of the evidence that residential placement is a medical necessity in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden to establish that such placement is a medical necessity.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for residential placement.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/07/2011

***** 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.