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:

Docket No. 2013-11560 CMH
Case No.

,

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 request for a hearing filed on behalf of Appellant/Petitioner.

After due notice, a hearing was held on . , Appellant's and guardian, appeared and testified on Appellant's behalf. , Appellant's case worker, also testified on Appellant's behalf. , Assistant Corporation Counsel, represented the Macomb County Community Mental Health Authority (CMH). , a supervisor at the CMH's Access Center, also testified as a witness for the CMH.

ISSUE

Did the CMH properly deny 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. Appellant is a year-old male with a legal guardian and who presents with a history of being diagnosed with personality disorder, bipolar disorder, schizophrenic tendencies, and Asperger's syndrome tendencies. Appellant has also been diagnosed with attention-deficit/hyperactivity learning disorder NOS and alcohol abuse. (Respondent's Exhibit A, pages 13, 20).

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

3. Appellant's guardian applied for CMH services on Appellant's behalf and

an initial intake was performed on [redacted]. Following that intake, Appellant was approved for services, including assessments, treatment planning, case management, psychotherapy, medication management, and community living supports (CLS). (Respondent's Exhibit A, pages 13-32).

4. While authorized for CLS, Appellant often refused to let his CLS worker into his home and the worker quit. (Testimony of Appellant's representative).

5. While authorized for medication management services, Appellant was non-compliant with his medications. (Testimony of Appellant's representative).

6. On or about [redacted], Appellant was admitted to the hospital. (Uncontested testimony during the hearing).

7. Subsequently, on [redacted], the CMH received a request for residential placement for Appellant. (Respondent's Exhibit A, page 41).

8. The CMH's Access Center reviewed the request and determined that it should be denied as it appeared that, with treatment, Appellant should be able to be maintained in the community. In particular, it was noted that, while Appellant had been non-compliant with his medication, the expectation was that he would be stabilized prior to being discharged from the hospital. The Access Center also noted that, while Appellant needs new CLS staff because his prior worker quit, he is authorized for a new worker and one can be found. (Respondent's Exhibit A, page 41; Testimony of [redacted]).

9. On [redacted], the CMH sent Appellant written notice stating that the request for "Adult Residential" was denied. The reason given in the notice was that "consumer does not meet criteria for services requested." (Respondent's Exhibit A, page 6).

10. The Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed on behalf of Appellant on [redacted], in which Appellant's representative stated that much had happened since the denial. (Respondent's Exhibit A, pages 8-9).

11. However, the request was not signed by Appellant and did not indicate that Appellant had a legal guardian. Accordingly, a letter was sent indicating that MAHS required a signature from Appellant or documentation regarding a guardianship in order to move forward.

12. On [redacted], letters of guardianship were received by MAHS and

this matter was scheduled for hearing.

13. As discussed above, the hearing was held on [redacted].

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.]
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> * * *
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> 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.]

Moreover, 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. CMHSP contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Additionally, Medicaid beneficiaries are only entitled to medically necessary 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.

Here, the applicable October 1, 2012 version of the Michigan Medicaid Provider Manual (MPM), Mental Health and Substance Abuse Chapter, Sections 2.5.C and 2.5.D provides in part:

> **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
>
> - <u>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</u>

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. [emphasis added]

In this case, 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 had only been receiving services in his home for a few months before the request for residential placement was made. While there were clearly many difficulties during that time period, it cannot be said at this time that this less restrictive level of treatment has been unsuccessful, especially where Appellant was non-compliant with his medication and refusing to let his CLS worker into his home. Moreover, as noted by the CMH, it was expected that both of those issues would be resolved after Appellant was stabilized and discharged from the hospital. The amount, scope and duration of the authorized services appears sufficient and, while this Administrative Law Judge appreciates the difficulties Appellant and Appellant's family are having, the MPM still requires that services be provided in the least restrictive, most integrated setting possible.

In the request for hearing and during the hearing itself, Appellant's representative and witness asserted that, while Appellant's situation has changed somewhat since the denial and, for instance, Appellant is now compliant with his medication, he still cannot live on his own. However, this Administrative Law Judge is limited to reviewing the information the Department had at the time the denial of long-term residential placement was made. Hence, information provided by the Appellant regarding any continuing difficulties that occurred after [REDACTED] 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.

With respect to the decision that is before this Administrative Law Judge, Appellant bears the burden of proving by a preponderance of the evidence that the requested residential placement is medically necessary and in accordance with the applicable policy and regulations. Here, as discussed above, Appellant did not meet the burden and the CMH'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 the CMH properly denied Appellant's request for residential placement.

IT IS THEREFORE ORDERED that:

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

/S/
Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

Date Mailed: 3/28/2013

***** 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.