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) 373-4147

IN THE MATTER OF:

Docket No. 2014-30311 CMH

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, a hearing was held on , Appellant's mother, appeared and testified on Appellant's behalf. Assistant Corporation Counsel, represented Respondent (CMH). , Director of the CMH's Access Center, 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. 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.

2. Appellant is year-old male who has been diagnosed with Bipolar disorder and has a history of substance abuse. (Respondent's Exhibit A, pages 10, 22, 28).

3. Appellant has been receiving services through the CMH, including supported housing; targeted case management; medication reviews; registered nurse services; and treatment planning. (Respondent's Exhibit A, pages 38-39).

4. Through the supported housing service, Appellant has been living in an apartment at the (semi-independent living arrangement) since . (Respondent's Exhibit A, page 18).

5. Appellant was placed in the after spending days in a hospital, where he had initially presented as paranoid and very suspicious. (Respondent's Exhibit A, page 18).

6. On , the CMH conducted an assessment of Appellant as part of the process of determining his services for the upcoming year. (Respondent's Exhibit A, pages 10-29).

7. During that assessment, it was noted that Appellant had no personal care needs and is able to groom and dress himself, clean his own apartment, and complete his own laundry. (Respondent's Exhibit A, pages 18, 29).

8. It was also noted that Appellant's parents are his payee for his social security checks, but that Appellant works part-time and spends the income he earns from that job. (Respondent's Exhibit A, pages 18, 29).

9. In addition to working part-time, Appellant also attends school at days a week. (Respondent's Exhibit A, page 33).

10. It was further noted during the assessment that the SIP's staff assists Appellant in scheduling his medical appointments. (Respondent's Exhibit A, pages 18, 29).

11. Following the assessment, Appellant's case worker recommended that the CMH reauthorize Appellant's residential placement for the upcoming year. (Respondent's Exhibit A, pages 18, 29).

12. In the case worker's view, Appellant needed more insight into his illness, a greater ability to schedule appointments and budget his money, and increased socialization if he was going to successfully live independently. (Respondent's Exhibit A, pages 18, 29).

13. However, the CMH's Access Center reviewed the request for residential placement and determined that it must be denied. (Testimony of).

14. On , the CMH sent written notice that it was denying the request for continuing residential placement and would only approve days of residential placement as a transition period. (Respondent's Exhibit A, page 6).

15. Regarding the reason for the denial, the notice stated: "Consumer has stabilized and can be served in less restrictive environment/has other resources." (Respondent's Exhibit A, page 6).

16. On [redacted], Appellant's parents/guardians requested a Local Dispute Resolution (LDR) hearing through the CMH. (Respondent's Exhibit A, page 31).

17. The LDR hearing was held on [redacted] and the CMH's decision was subsequently upheld in a decision issued by the hearing officer on [redacted]. (Respondent's Exhibit A, pages 31-33).

18. On [redacted] the Michigan Administrative Hearing System (MAHS) receiving the request for hearing filed in this case. (Respondent's Exhibit A, page 8).

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

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.

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. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the Michigan Medicaid Provider Manual (MPM) states:

> **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, January 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 12-14
(Underline added by ALJ)

Similarly, regarding the location of services, the MPM states in part:

> **2.3 LOCATION OF SERVICE**
>
> Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

MPM, January 1, 2014 version
Mental Health/Substance Abuse Chapter, page 9
(Underline added by ALJ)

Here, while approving a transition period, the CMH denied the request for residential placement on the basis that such placement was not medically necessary. According to the CMH's witness, Appellant has stabilized to the point where he can be serviced in a less restrictive environment.

In response, Appellant's representative testified that Appellant has made significant improvement while living in the [redacted] and that she does not want Appellant to regress by removing him from that environment too soon. She also noted how beneficial it has been for Appellant to have someone other than his parents checking up on him.

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).

Given the above evidence and policies, Appellant did not meet that burden of proof and the CMH's decision must therefore be affirmed. As noted in the above policy, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been unsuccessful or cannot be safely provided for Appellant and, in this case, there exists a more clinically appropriate, less restrictive and more integrated setting in the community for Appellant.

While no exact living situation has been chosen, any independent setting is clearly less restrictive than the requested residential placement and Appellant has not shown that such a restrictive setting is necessary. Instead, the undisputed evidence demonstrates that Appellant's conditions and behavior have stabilized; he has a part-time job; he

attends school days a week; he owns and drives a car; and that he is independent with respect to his personal care needs. Moreover, to the extent Appellant does require further services, such as assistance with managing money or scheduling medical appointments, such assistance can be provided in a less restrictive setting. The mere fact that Appellant's representative is worried that the now-stable Appellant will regress is insufficient on its own to justify a more restrictive setting and she failed to identify any necessary services that would justify such a setting.

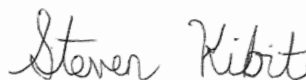
The MPM requires that services be provided in the least restrictive, most integrated setting possible, and Appellant's representative has failed to meet her burden of proving by a preponderance of the evidence that a residential placement is a medical necessity in accordance with the Code of Federal Regulations.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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



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

Date Signed:
Date Mailed:

SK/db
cc:

***** 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.