RICK SNYDER
GOVERNOR

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

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: March 23, 2016
MAHS Docket No.: 15-023393
[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 the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Petitioner appeared and testified on her own behalf. [redacted], an administrator at Petitioner's Supported Independent Placement (SIP), also testified as a witness for Petitioner. [redacted], Assistant Corporation Counsel, represented the Respondent [redacted] County Community Mental Health. [redacted], Clinical Psychologist and Access Center Supervisor, testified as a witness for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for reauthorization of her adult 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. Petitioner is a [redacted]-year old Medicaid beneficiary who has been diagnosed with schizoaffective disorder (Exhibit A, page 19

2. For at least the past [redacted] years, Petitioner has been receiving services through Respondent that included an adult residential placement at the [redacted]. (Exhibit A, page 17).

3. On [redacted], Respondent conducted an Annual Assessment of Petitioner's needs and services. (Exhibit A, pages 12-21).

4. During that assessment, Respondent's staff noted that Petitioner has remained psychiatrically stable over the past year and has not had any inpatient hospitalizations in over eighteen years. (Exhibit A, pages 17-18).

5. It was also noted that Petitioner continues to attempt to increase her independence in her apartment setting, but refuses to use public transportation. (Exhibit A, page 18).

6. It was further noted that Petitioner needs to be monitored while she administers her own medications and is reliant on staff for ordering medications and providing transportation, but that she is independent in all activities of daily living and is capable of cooking for herself. (Exhibit A, page 18).

7. At the annual assessment, Petitioner requested that her adult residential placement continue. (Exhibit A, page 21).

8. On [redacted], Respondent sent Petitioner written notice that her request for reauthorization of her adult residential placement had been denied. (Exhibit A, pages 6-8).

9. Specifically, the notice stated that the request was denied because Petitioner "has stabilized and can be served in a less restrictive environment." (Exhibit A, page 6).

10. The notice also provided that the placement would be approved for [redacted] days. (Exhibit A, page 6).

11. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, page 10).

12. Petitioner also requested a [redacted]) Hearing with Respondent. (Exhibit A, page 29).

13. The [redacted] hearing was held on [redacted]. (Exhibit A, page 29).

14. On [redacted], the Hearing Officer issued decision affirming the denial of residential services, but also extending the authorization of services to [redacted]. (Exhibit A, pages 29-32)

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).

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible and 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 the location of such services, the applicable version of the Michigan Medicaid Provider Manual (MPM) states in part:

> **2.3 LOCATION OF SERVICE [CHANGE MADE 7/1/15]**
>
> 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, October 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, page 9*

Moreover, regarding medical necessity, the MPM also 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, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 12-14
(Emphasis added)

Here, Respondent denied Petitioner's request for continuation of her adult residential placement in a [redacted]. Regarding the reason for the action, the notice of denial stated that Petitioner had stabilized and could be served in a less restrictive environment. In support of the decision, the Respondent's witness also the more restrictive [redacted] is unnecessary given that Petitioner is psychiatrically stable; she does not require the around-the-clock care available at the [redacted]; she is independent in all activities of daily living; she can cook her own meals and clean her residence; and any needs she does have could be met through Community Living Supports (CLS) and/or Home Help Services (HHS) provided in a less-restrictive setting.

In response, Petitioner testified that, if her placement is terminated, she will have no one to provide transportation for her shopping, banking or other personal business. She also testified that she can perform all those tasks on her own, in addition to any other personal care tasks, but that she cannot afford alternative transportation. According to Petitioner, the only services she needs and receives through the [redacted] is transportation. She further testified that she has tried to arrange transportation through [redacted] or [redacted] but was unsuccessful. She also noted that she only has [redacted] per month to live on.

The administrator at Petitioner's [redacted] testified that Petitioner does not receive around-the-clock services through her program at the [redacted] and that, while staff check on her during the day, there is really no one there overnight. He also testified that, in addition to transportation, staff assist Petitioner with personal hygiene, cooking and cleaning.

Petitioner bears the burden of proving by a preponderance of the evidence that the Respondent erred in denying her request for continuation of her adult residential placement.

Given the evidence and applicable policies in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed. Petitioner, her witness from the [redacted], and Respondent all present different accounts of what services Petitioner is receiving at the [redacted], but all three accounts also demonstrate that Petitioner's needs could be met in a less restrictive environment and that the adult residential placement is not medically necessary. For example, Petitioner only seeks transportation and transportation needs alone do not warrant a residential placement. Similarly, her witness from the [redacted] only identified a need for transportation and some personal care assistance, none of which requires an adult residential placement, and he expressly testified that the [redacted] does not have staff available around-the-clock to assist Petitioner. Moreover, while Respondent asserts that the [redacted] should have had staff available around-the-clock, it also asserts that Petitioner no longer needs such care and the limited needs she does need could be met through CLS and/or HHS provided in a less-restrictive setting. Accordingly, whatever testimony is accepted, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for reauthorization of her adult residential placement.

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

Petitioner

[redacted]

DHHS -Dept Contact

[redacted]

Counsel for Respondent

[redacted]

DHHS-Location Contact

[redacted]