RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 15-018793
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

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

A hearing scheduled for [redacted] was adjourned per Respondent's request and rescheduled for [redacted]. The [redacted] hearing was converted to a Prehearing Conference per Petitioner's request and, following the Prehearing Conference, the matter was scheduled for hearing on [redacted]. The [redacted] hearing was adjourned per Petitioner's request and rescheduled for [redacted]. The [redacted] hearing was also adjourned per Petitioner's request and rescheduled for [redacted]. The [redacted] hearing proceeded as scheduled.

Attorney [redacted] appeared on Petitioner's behalf. [redacted], Therapist, [redacted]; [redacted], [redacted], [redacted]; A[redacted], Autistic Services Manager, [redacted]; [redacted], Contract Manager, [redacted] mother; and [redacted] father were called as witnesses on Petitioner's behalf.

[redacted], Fair Hearings Officer, [redacted], appeared and testified on behalf of [redacted] ([redacted] CMH or Department).

ISSUE

Did the CMH properly deny Petitioner's request for placement in a residential treatment facility?

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, born [redacted]. (Exhibit 3, p 1; Testimony)

2. [redacted] is under contract with the Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Testimony)

3. Petitioner is diagnosed with Bipolar Disorder, Anxiety Disorder, Cognitive Disorder and Fetal Alcohol Syndrome (FAS). (Exhibit 3, p 1; Testimony)

4. Petitioner is currently prescribed the medications Lithium Carbonate, Intuniv, Zyprexa, Zyprexa and Amantadine. (Exhibit 3, p 1; Testimony)

5. Petitioner was adopted at 3 months of age by his parents [redacted]. Petitioner has two siblings who also have special needs. (Exhibit 3, p 2; Testimony)

6. Petitioner struggles with controlling his emotions and will have outbursts of anger where he is physically aggressive towards his parents and siblings. (Exhibit 3, p 1; Testimony)

7. Petitioner has been involved in home-based services since [redacted] with on and off care due to residential placements. Petitioner has a long history of treatment from inpatient hospitalizations including seven visits to [redacted] and a one month long visit to the [redacted] Petitioner has also had wrap-around services, psychiatric services, respite, parent support partners, home-based services, and CLS services to assist him in learning skills and supporting him to remain in the home. (Exhibit 3, pp 2-3; Testimony)

8. Despite all of these services, and due to safety concerns for both Petitioner's parents and siblings, he was placed at the [redacted], part of [redacted], in [redacted] with a plan of working with multiple service providers to assist Petitioner in working on skills to decrease his aggression towards others. (Exhibit 3, p 1; Testimony)

9. Part of the payment for Petitioner's placement at [redacted] came from an adoption subsidy Petitioner's family receives from the state of [redacted], where Petitioner was adopted. (Testimony of [redacted])

10. In [redacted], Petitioner's family requested a more intensive residential placement for Petitioner after [redacted], [redacted], informed the family that Petitioner had met the maximum benefit of their treatment program. Specifically, the family requested that Petitioner be placed at [redacted] Program ([redacted]. (Exhibit 3, pp 1, 3; Exhibit 5; Testimony)

11. On [redacted], [redacted] provided Petitioner's parents with a Notice of Action which indicated that the request for residential treatment was denied. Specifically, the Notice indicated that residential treatment was denied because: "Child has another funding source that provides a residential benefit." The other funding source [redacted] was referring to was the adoption subsidy Petitioner's family receives from the state of [redacted], where Petitioner was adopted, and which was paying for his services at [redacted]. (Exhibit A, p 3; Testimony)

12. On [redacted], Petitioner's first Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1)

13. On [redacted], Petitioner's family placed Petitioner at [redacted] because the facility had an opening and the family was concerned that the spot would go to someone else if they did not take it. Petitioner's adoption subsidy pays for all but approximately $1500.00 to $2,000.00 per month of the cost of Petitioner's placement at Chaddock. (Exhibits 3, 5; Testimony)

14. On [redacted] following an additional request for residential placement at [redacted] and after a meeting of [redacted] Residential Committee, [redacted] issued a second denial of the request for residential treatment. Specifically, this Notice indicated, "Clinically necessary services can be met through [redacted] Providers through available ancillary services, home based WRAP, CLS, psychiatric through [redacted] providers." (Exhibit A, pp 4-5; Testimony)

15. On [redacted] Petitioner's second Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services 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.*

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Sections 2.3, 2.5.C and 2.5.D provide*:

> **2.3 LOCATION OF SERVICES**
>
> 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.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. 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 home.
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> For beneficiaries residing in nursing facilities, only the following clinic services may be provided:
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> - Nursing facility mental health monitoring;
> - Psychiatric evaluation;
> - Psychological testing, and other assessments;
> - Treatment planning;
> - Individual therapy, including behavioral services;
> - Crisis intervention; and

- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of [redacted]. For both the CCI and [redacted], the **(revised 7/1/15)** following mental health services initiated by the PIHP (the case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI or [redacted] This should occur up to 60 days prior to the anticipated discharge from a CCI or Hawthorn Center.

- Wraparound planning or case management. This should occur up to 60 days prior to discharge from a CCI or Hawthorn Center. **(revised 7/1/15)**

Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

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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 Chapter
October 1, 2015, pages 9-10, 14

The Department first argues that its denial of Petitioner's request for out-of-state residential placement was proper because Petitioner has another funding source for that placement, namely the adoption subsidy Petitioner receives from the state of [redacted] The Department points out that Medicaid is the payor of last resort and that other resources must be considered before Medicaid funds are used. The Department also argues that Petitioner's needs can be met by other services available through [redacted] such as home based WRAP, CLS, and psychiatric services through [redacted] The Department also argues that out-of-state placement is not a best practice for Medicaid services and points to language from the Medicaid Provider Manual, Mental Health Substance Abuse Chapter, Section 2.3 Location of Services, outlined above.

Petitioner argues that because he is receiving Federal 4-E funds, he cannot be denied Medicaid. Petitioner further argues that the notices given to Petitioner were faulty because they did not include information regarding one of the Department's arguments at hearing, namely that it is not a best practice to use Medicaid funds away from the family and local community. Petitioner argues that he requires residential placement, as evidenced by his multiple stays in psychiatric hospitals and his placement at a group home for the entire year leading up to the denials in this matter. Petitioner also argues that the Department was at fault for not assisting Petitioner further when he was looking to leave [redacted] and that the Department should have provided assistance and research for alternative placements.

Petitioner 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) and Medicaid policy. Based on the evidence presented, Petitioner did not meet the burden to establish that the Department erred in denying his request for residential placement. Here, Petitioner's family moved Petitioner to [redacted] on [redacted] some two weeks prior to a meeting held with [redacted] residential committee to determine if residential placement could be approved. The

move also occurred some six weeks after [redacted] had denied Petitioner's request for residential treatment because he had another funding source for the services, which he had been using at [redacted] All Medicaid services must be approved before they are implemented and Petitioner failed to obtain prior authorization for the move to [redacted] before it was made. Based on that fact alone, Petitioner's appeal must fail. And while Petitioner may have had an argument that he required residential placement, based on his prior hospitalizations and placement at [redacted] those arguments are moot given that Petitioner moved to [redacted] before receiving prior authorization for the move.

Furthermore, Petitioner's argument that he cannot be denied Medicaid is without merit because [redacted] is not denying Petitioner Medicaid, it is denying Petitioner out-of-state residential placement. [redacted] offered a myriad of other Medicaid services in place of the out-of-state placement. Petitioner's argument that the Notices provided by [redacted] are also faulty because, again, Petitioner's family moved him to [redacted] before receiving authorization to do so. Finally, while [redacted] could have probably provided more assistance to Petitioner and his family during the time in question, Petitioner's family was receiving the assistance of [redacted] contracted provider, [redacted] whose employees were working closely with Petitioner's family during the time in question.

Based on the above, Petitioner's request for residential placement was properly denied.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

RM/cg

Robert J. Meade
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

Counsel for Appellant [redacted]

DHHS -Dept Contact [redacted]

Petitioner [redacted]

Counsel for Respondent [redacted]

DHHS-Location Contact [redacted]

DHHS-Location Contact [redacted]