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: May 2, 2016
MAHS Docket No.: 16-002342
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 hearing was held on [redacted]. [redacted], Petitioner's Father appeared on behalf of the Petitioner. [redacted] appeared as a witness for the Petitioner. CJ Witherow, Fair Hearings Officer, represented the Lenawee Community Mental Health Authority (Department). Claudia Moeller, Supports Coordinator, John Berridge, Supervisor for Developmental Disabled, appeared as witnesses for the Department.

Exhibits

Petitioner	None[1]
Department	A – Hearing Summary

ISSUE

Did the Department properly deny the Petitioner's request for residential placement?[2]

[1] Petitioner presented several exhibits. They included medical records, school incident reports and still pictures and video recordings. The exhibits were either not relevant or were not requested to be part of the record.

[2] The Petitioner indicated the issue at the hearing was related to the denial for residential placement only and not regarding an issue with respite hours.

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 15 year-old Medicaid beneficiary, born [redacted], who has been diagnosed with intermittent explosive disorder, Tourette's disorder, and moderate intellectual disabilities. (Exhibit A, p. 7, 15; Testimony).

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. (Testimony).

3. On [redacted], the Petitioner began receiving services from the Department. (Testimony).

4. On [redacted] an Individual Plan of Services (IPOS) was completed regarding the services to be provided to the Petitioner. The dates of coverage were from [redacted] through [redacted]. (Exhibit A, p. 6; Testimony).

5. The [redacted] IPOS provided the Petitioner with 40 hours per month of Behavioral Services for the family; 4 hours per month of individualized behavioral therapy and 6 hours per week of respite. (Exhibit A, pp. 7-12; Testimony).

6. Monitoring of the IPOS includes direct contact and observation of the Petitioner and Petitioner's family, contact with the Petitioner's school and psychologist as well as a review of the services that are being utilized. (Testimony).

7. From [redacted] through [redacted], the Petitioner was using approximately half of the individualized behavioral therapy hours that were allotted in the [redacted] IPOS agreement. (Testimony).

8. From [redacted] through [redacted], the Petitioner was using approximately less than half of the Behavioral Services for the family hours that were allotted in the [redacted] IPOS agreement.

9. Reasons the therapy hours provided were not being fully utilized included issues with the family not allowing therapy in the morning from a female therapist, family appointment cancellations, therapist appointment cancelations, Petitioner's father's evening work schedule. (Testimony).

10. On or around [redacted], the Petitioner requested residential placement. (Exhibit A, p. 1; Testimony).

11. The Department discussed with the Petitioner's behavioral psychologist (BP). The BP indicated that he did not believe out of home placement was what was needed. The BP indicated issues primarily arise in the morning and that the family does not want them there in the morning with a female tech and that he was working on finding a male tech to resolve this concern. BP indicated he was not at a loss regarding what is happening and how to work on it and believed that the more they could get access to the Petitioner the more they could accomplish. (Exhibit A, p. 41; Testimony).

12. In reviewing the request, the Department reviewed psychological assessments and progress notes from the prior months and did not find anything to suggest the treatment thus far had been unsuccessful. (Exhibit pp. 13-33; Testimony).

13. On [redacted], the Department sent the Petitioner an Adequate Negative Action notice. The notice indicated the residential placement request was being denied as Medicaid funds are for support and treatment in the least restrictive, most integrated setting possible and that the Petitioner's current treatment has not been unsuccessful. (Exhibit A, p. 1; Testimony).

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).

The opening section in the Medicaid Provider Manual (MPM), Children's Home and Community Based Waiver Program (CWP) states:

> The Children's Home and Community Based Services Waiver Program <u>(CWP) provides services that are enhancements or additions to regular Medicaid coverage</u> to children up to age 18 who are enrolled in the CWP.
>
> The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the

> CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.
>
> Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDCH must be submitted to the CWP Clinical Review Team at MDCH. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist. [MPM, July 1, 2014 version, Mental Health and Substance Abuse Chapter, Section 14 (emphasis added).]

Therefore, as Children's Waiver services are simply an enhancement and addition to regular Medicaid services, which do contemplate residential placements; those services can be provided through the CWP.

To the extent residential placements can be authorized through the CWP, the MPM only allows residential placements in Child Caring Institutions (CCI), in certain circumstances:

> **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.
>
> * * *
>
> <u>Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is for the purpose of transitioning a child out of an institutional setting (CCI).</u>
>
> * * *
>
> <u>Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves</u>

> 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). [MPM, July 1, 2014 version, Mental Health and Substance Abuse Chapter, Section 2.3 (emphasis added).]

However, even if the requested residential placement is a covered service under both the CWP and Medicaid in general, 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 April 1, 2016 version of the MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, 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;
> - 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;

- 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:
  - 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. [emphasis added]

The Petitioner's family argued the Petitioner had a long history of being both physically abusive to himself and others and that his behavior was uncontrolled and erratic. The Petitioner indicated that because of this behavior, residential placement would be the best place for him.

The Department did not dispute the Petitioner's history of being physically abusive. Rather they argued the Petitioner had been enrolled with them for less than a year and that even though the services allocated to the Petitioner were not being fully utilized,

there was no evidence that the services being provided were not successful. As a result, the Department was of the position that as it was, the current placement was the least restrictive setting and one that at the moment meets the Petitioner's needs.

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." Given the evidence provided, it cannot be said at this time that the current level of treatment in his is unsuccessful or cannot be safely provided.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

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

CA[redacted]

Corey Arendt
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

DHHS-Location Contact

[redacted]
Lenawee County CMHSP
1040 South Winter St
Adrian, MI
49221-3867

DHHS Department Rep.

[redacted]
Monroe County CMH
1001 South Raisinville Rd.
Monroe, MI
48161-0726

Petitioner

[redacted]

DHHS -Dept Contact

[redacted]
320 S. Walnut St.
5th Floor
Lansing, MI
48913