RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: July 11, 2016
MAHS Docket No.: 16-006005
Agency No.:
Petitioner:

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 July 6, 2016. , Petitioner's mother, appeared on behalf of the Petitioner. , appeared as a witness for the Petitioner. , Manager of Due Process, appeared on behalf of County Community Mental Health (Department). , Clinical Supervisor and , Manager of Utilization Management and Review, appeared as witnesses for the Department.

Exhibits

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny the Petitioner's request for long-term hospitalization?

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 year-old Medicaid beneficiary, born , who has been diagnosed with post-traumatic stress disorder, attention-deficit/hyperactivity disorder, dis-hyperactive disorder, oppositional defiant disorder and reactive attachment disorder. (Exhibit A, p. 23; 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. In October of 2015, a LUNA assessment was conducted. The assessment indicated the Petitioner would benefit from a highly structured environment that would help her better understand what is expected of her and what to expect of her environment. (Testimony).

4. Prior to December of 2015, the Petitioner was approved for and receiving services from the Department. (Testimony).

5. In December of 2015, the Department closed the Petitioner's case due to a lack of engagement and no response from the Petitioner's Mother. At the time, the Petitioner's Mother did not feel the services being provided were helpful and that they were a waste of time. Specifically, the Petitioner's Mother questioned the therapy the Petitioner was receiving and questioned the ability of the therapist who was providing therapy. (Exhibit A, p. 3; Testimony).

6. In March of 2016, the Petitioner's Mother contacted the Department about re-enrolling the Petitioner with the Department. (Testimony).

7. In March of 2016, the Department, re-assessed the Petitioner and authorized psychiatric reviews, medication reviews outpatient services, family therapy, group therapy and Community Living Support (CLS) services. (Exhibit A, p. 22; Testimony).

8. The services allocated in March of 2016 were greater in scope than the services authorized the previous year.

9. From March 24, 2016 through April 14, 2016, the Petitioner participated in a Sanctuary program. The program is similar to respite care in that it is to provide the family with temporary relief. (Exhibit A, p. 2; Testimony).

10. On April 25, 2016, the Petitioner was authorized to attend a partial hospitalization program called Face 2 Face. (Exhibit A, p. 2; Testimony).

11. On or around April 26, 2016, the Petitioner's Mother requested the Petitioner be admitted to a State Hospital for long-term inpatient care. (Exhibit A, p. 2; Testimony).

12. Prior to April 26, 2016, the Petitioner had been screened by Common Ground for inpatient hospitalization and had been denied both times. (Exhibit A, p. 2; Testimony).

13. As of April 26, 2016, the Petitioner’s school indicated the Petitioner was doing well. (Exhibit A, p. 9).

14. Petitioner has no history of violence or self-harm other than throwing an apple at another student. (Exhibit A, p. 3; Testimony).

15. Petitioner did receive treatment in the spring of 2016 regarding a report of self-harm. However, the Petitioner was not admitted and when the Petitioner was asked whether or not she had made comments regarding self-harm, she denied them. (Testimony).

16. On April 29, 2016, the Department issued a notice indicating they did not support out of home residential treatment nor state facility treatment due to the availability of less restrictive options for services and supports to meet medical necessity. (Exhibit A, p. 4; Testimony).

17. On or around May 2, 2016, the Department denied the Petitioner’s request for state facility treatment due to the availability of less restrictive options for services and supports to meet medical necessity. (Testimony).

18. On May 13, 2016, the Michigan Administrative Hearings System (MAHS) received from the Petitioner a request for hearing.

19. On June 13, 2016, the Petitioner requested a second opinion. (Exhibit A, p. 8; Testimony).

20. On or around June 13, 2016, the Department issued a second opinion. The second opinion affirmed the earlier determination and held the criteria for state facility admission was not met. (Exhibit A, p. 9; Testimony).

21. As of July 6, 2016, the Petitioner had not utilized CLS services. (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 (CWP) provides services that are enhancements or additions to regular Medicaid coverage 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.
>
> * * *

> 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).
>
> * * *
>
> 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). [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 was not receiving the help she needed and that her services have not changed since 2009. Although this argument was made, the facts demonstrated the petitioner’s benefits have increased in scope since the fall of 2015 and it was the Petitioner who stopped utilizing the services allocated in the fall of 2015. The fact the Petitioner failed to utilize the services being offered is evidence that there was a lack of necessity regarding the services that were being provided.

The Department argued there were services they could provide in less restrictive settings that would meet the Petitioner’s needs. Additionally, the Department indicated the Petitioner had been denied inpatient hospitalization during two recent assessments and that there was no evidence that the Petitioner posed a threat to herself or others.

Lastly, the Petitioner has not shown any evidence that she was fully utilizing the services that were being provided. The evidence shows that at least once in the prior 12 months, the Petitioner failed to utilize services that led to a case closure and most recently the Petitioner was approved for CLS hours however, those services have not yet been utilized.

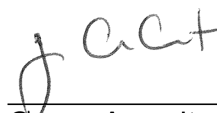
Clearly, Petitioner’s placement in her own home is less restrictive than any residential placement. Furthermore, as noted above, “Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided.” Given the evidence provided, it cannot be said at this time that the current level of treatment is unsuccessful or cannot be safely provided. As such, the Department’s actions are affirmed.

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 long-term hospitalization.

IT IS THEREFORE ORDERED that

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



CA/

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 -Dept Contact

DHHS Department Rep.

Petitioner