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: October 31, 2016
MAHS Docket No.: 16-010403 (CMH)
Agency No.: [redacted]
Petitioner: [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 a request for a hearing filed on Petitioner's behalf.

After due notice, a telephone hearing was held on September 28, 2016. [redacted], Petitioner's father and co-legal guardian, appeared and testified on Petitioner's behalf. [redacted], Petitioner's mother and co-legal guardian, also testified as a witness for Petitioner. Attorney [redacted] represented the Respondent [redacted]. [redacted], Program Supervisor, and [redacted], Supports Coordinator, testified as witnesses for Respondent. [redacted], Regional Customer Services Specialist, and [redacted], Chief Operating Officer, were also present for Respondent during the hearing.

ISSUE

Did Respondent properly deny Petitioner's request for residential placement at a facility outside of Respondent's network of providers?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Respondent is a Community Mental Health Services Program (CMHSP) affiliated with a Prepaid Inpatient Health Plan (PIHP), the Mid-State Health Network. (Testimony of [redacted]).

2. Petitioner is a twenty-five-year-old Medicaid beneficiary who has been diagnosed with cerebral palsy; mental retardation, severity unspecified; asthma; a chronic ear condition; osteoporosis; and a history of seizures when he was a minor. (Exhibit 5, pages 1, 6)

3. On February 10, 2016, Petitioner was screened for services through Respondent. (Exhibit 5, pages 1-7).

4. During that screening, it was reported that Petitioner is basically non-verbal, he requires total care, and he uses a wheelchair for mobility. (Exhibit 5, pages 4-5).

5. Petitioner was further found to have substantial difficulties with initiating and performing tasks independent of support. (Exhibit 5, page 5).

6. Based on those impairments, Petitioner was found to be eligible for services through Respondent. (Exhibit 5, page 7).

7. On [redacted], Respondent conducted an Initial Biopsychosocial Assessment with Petitioner. (Exhibit 7, pages 1-12).

8. During that assessment, it was again reported that Petitioner is basically non-verbal and that he relies on others for all his personal care needs. (Exhibit 7, page 2).

9. It was also reported that Petitioner relies on a G-tube for the majority of his nutrients and that he requires around-the-clock supervision to maintain his safety. (Exhibit 7, pages 6, 9-10).

10. At the time of the screening and assessment, Petitioner was living part-time with his mother and part-time at an assisted living facility owned by [redacted], Inc. ([redacted]e"). (Exhibit 5, page 7; Exhibit 7, page 12; Testimony of Petitioner's father).

11. During the assessment, Petitioner's legal guardians also reported that [redacted] is not currently receiving any funding for providing care and that, with assistance and funding from Respondent, Petitioner's family would like to move him there full-time. (Exhibit 7, page 2).

12. An Interim Person-Centered Plan (PCP) meeting was also held on [redacted]. (Exhibit 8, pages 1-3).

13. A goal of assisting Petitioner and his family with assessing available resources was developed during that meeting and supports coordination services were approved. (Exhibit 8, pages 1-3).

14. Subsequently, two scheduled follow-up meetings had to be rescheduled and the parties did not meet again until March 9, 2016. (Exhibit 9, pages 1-5).

15. During that March 9, 2016 meeting, Petitioner's supports coordinator and family discussed Petitioner being placed at [redacted] or at a specialized residential facility within Respondent's network of providers, with Petitioner's family indicating a desire for Petitioner to be placed at [redacted]. (Exhibit 9, page 4).

16. On April 8, 2016, another meeting was held and, during that meeting, Petitioner's supports coordinator; Petitioner's legal guardians; a representative from [redacted], and a representative from [redacted], a facility within Respondent's network of providers; discussed Petitioner's needs and what might be an appropriate placement for him. (Exhibit 10, pages 1-5).

17. Petitioner's supports coordinator also informed the family that no decision regarding Petitioner's requested placement at [redacted] had been made and that the supports coordinator would be in contact when one was made. (Exhibit 9, page 6).

18. On April 12, 2016, the supports coordinator informed Petitioner's legal guardians that Respondent had sufficient capacity within its current provider network to meet Petitioner's needs and that it was not looking to expand its network at that time. (Exhibit 9, page 7).

19. The supports coordinator also advised Petitioner's legal guardians that Respondent currently has a placement available within its network at [redacted] (Exhibit 9, page 7).

20. Petitioner's father responded that they were willing to look into the placement, but that their preference was still [redacted]. (Exhibit 9, page 7).

21. Petitioner's father also asked for a written notice of any decision by Respondent to deny a placement at [redacted]. (Exhibit 9, page 7).

22. On April 15, 2016, Petitioner's legal guardians toured the [redacted] facility. (Exhibit 9, page 8).

23. On April 18, 2016, Petitioner's father advised Petitioner's supports coordinator that they were against the placement there because they believed Petitioner is not a good match with the other residents and because they would not be able to fit a shower chair in the bathroom. (Exhibit 9, page 9).

24. Petitioner's supports coordinator advised [redacted] father that they could explore alternative adaptive equipment that would meet Petitioner's needs, but they also agreed to pursue other residential options. (Exhibit 9, page 9).

25. On April 20, 2016, Petitioner's supports coordinator identified two other potential residential options for Petitioner within Respondent's network of providers. (Exhibit 9, page 10).

26. On April 28, 2016, Petitioner's legal guardians toured the two facilities. (Exhibit 9, page 12).

27. On May 13, 2016, Petitioner's father advised Petitioner's supports coordinator that he and Petitioner's mother has decided that neither of the recently toured facilities could adequately meet Petitioner's needs. (Exhibit 9, page 15).

28. In response, Petitioner's supports coordinator advised him that they could being looking at facilities outside of [redacted] County, but still within Respondent's network of providers, that may be suitable for Petitioner. (Exhibit 9, page 15).

29. On May 26, 2016, Petitioner's supports coordinator and Petitioner's father again discussed Petitioner's placement options, with Petitioner's father again reiterating that he and Petitioner's mother wanted him placed at [redacted]. (Exhibit 9, page 16).

30. On May 27, 2016, Petitioner's supports coordinator and her supervisor spoke with Petitioner's mother about Petitioner's placement options, including Petitioner's mother's concerns about the facilities proposed by Respondent. (Exhibit 9, page 17).

31. Subsequently, Petitioner's legal guardians and supports coordinator had additional conversations regarding whether Petitioner was still interested in pursuing a placement and, if so, whether he would consider non-local options. (Exhibit 9, pages 18-26).

32. On June 30, 2016, Petitioner's supports coordinator met with Petitioner at [redacted], where she also noted that he was doing well. (Exhibit 9, page 27).

33. On July 25, 2016, Petitioner's father advised Petitioner's supports coordinator that he and Petitioner's mother has decided that they wished for Petitioner to remain at [redacted] and wanted to file a grievance. (Exhibit 9, page 29).

34. On August 4, 2016, the Michigan Administrative Hearing System received the request for hearing filed in this matter on Petitioner's behalf regarding Respondent's decision not to pay for placement in a residential program at [redacted]. (Exhibit 3, pages 2-4).

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. 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**
>
> 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, 2016 version*
> *Mental Health/Substance Abuse Chapter, page 9*

Moreover, regarding medical necessity, the MPM also provides:

> **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, 2016 version
Mental Health/Substance Abuse Chapter, pages 13-14

Moreover regarding the Respondent's use of provider networks, the MDHHS-PIHP Contract provides:

Provider Networks
At the time of provider enrollment or re-enrollment in the PIHP's provider network, the PIHP must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs.

* * *

37.0 PROVIDER PROCUREMENT

The PIHP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. Where the PIHP and its provider network fulfill these responsibilities through subcontracts, they shall adhere to applicable provisions of federal procurement requirements as specified in Attachment P.37.0.1.

In complying with these requirements and in accordance with 42 CFR 438.12, the PIHP:

1. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification;
2. Must give those providers not selected for inclusion in the network written notice of the reason for its decision;
3. Is not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries, and is not precluded from using different practitioners in the same specialty. Nor is the PIHP prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, the PIHP's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, the PIHP must ensure that it does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

*** * ***

4.10 Out of Network Responsibility

If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network. Since there is no cost to

the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically-necessary specialty services provided out-of-network.

* * *

6.0 PIHP ORGANIZATIONAL STRUCTURE

The PIHP shall maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program inclusive of all behavioral health specialty services. The PIHP's management approach and organizational structure shall ensure effective linkages between administrative areas including: provider network services; customer services, service area network development; quality improvement and utilization review; grievance/complaint review; financial management and management information systems. Effective linkages are determined by outcomes that reflect coordinated management.

* * *

7.0 PROVIDER NETWORK SERVICES

The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks.

Medicaid Managed Specialty Supports and Services
Concurrent 1915(b)/(c) Waiver Program FY 16,
Pages 29-30, 39, 41, 44
(Emphasis added)

Here, Respondent denied Petitioner's request for residential placement at a facility outside of Respondent's network of providers.

In support of the decision, [redacted] testified that Petitioner needs around-the-clock care and is eligible for many Medicaid-covered services, including [redacted], but that residential services are not specifically covered by [redacted] and it is not medically necessary that Petitioner receive the services he does qualify for at [redacted] She also testified that [redacted] does not meet Respondent's licensing criteria and that, while Petitioner's guardians have concerns about the locations identified by Respondent, those concerns can all be

addressed. [redacted] further noted a potential conflict of interest with [redacted], as Petitioner's grandmother owns it and Petitioner's father works at one of its facilities

In response, Petitioner's father initially clarified that [redacted] is a corporation and, while he does not know its exact makeup, he does know that his mother is the primary owner. He also testified that he is employed at [redacted] as a [redacted], though not at the location where Petitioner lives. Regarding that particular location, Petitioner's father testified that it was licensed in the past and that other locations within [redacted] are licensed now. Petitioner's father further testified that [redacted] is head-and-shoulders above other locations offered by Respondent as it is accredited by The [redacted] it has nurse on staff around-the-clock, though Petitioner does not require nursing at all times; it has a therapist on staff; and is wheelchair accessible. He also testified that Petitioner has been getting excellent care at [redacted] Petitioner is familiar with everyone with everyone there; and that the other options offered by Respondent do not have the trained staff or equipment Petitioner needs.

Petitioner's mother also testified that she does not like the ratio of staff to patients at some of the locations offered by Respondent and that one of them is completely inappropriate given its carpets and Petitioner's allergies. She further testified that none of the options offered by Respondent are suitable given Petitioner's equipment needs and that, while she was told that environmental modifications are possible and that equipment can be bought, the placements are not set up for what Petitioner needs and there was no accessible bathroom given Petitioner's use of a Hoyer Lift and wheelchair. Petitioner's mother also testified that it can take time for Petitioner to get comfortable with people and for them to learn how to interact with him, but that he and the staff at [redacted] already know each other. She also noted that many of [redacted] residents are closer in age to Petitioner than at other locations.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request.

Given the record in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must, therefore, be affirmed. As provided above, Respondent is both required to develop a provider network and allowed to limit that network by choice, and it need only approve services through a non-network provider when it is unable to provide the necessary medical services through its network. Here, any specific services requested by Petitioner appear to have been approved, just not at the particular location/provider requested by Petitioner. That decision is proper given that the requested provider is outside of Respondent's provider network, and Petitioner failed to show any medical necessity for the particular location requested. For example, [redacted] may have a nurse onsite around-the-clock, but it is also conceded that Petitioner does not need that. Similarly, [redacted] may be CARF accredited, but there is no suggestion that Petitioner needs everything that goes into being so accredited. Moreover, while it is undisputed that environmental modifications or other adjustments

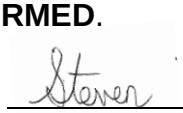
may need to be made at the locations, those modifications and adjustments can be made. A mere preference or comfort level with a particular provider is insufficient to show that the provider is medically necessary, especially where other options have not yet even been tried, and the undersigned Administrative Law Judge, therefore, finds that Petitioner has not met his burden of proving that Respondent erred.

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 residential placement at a facility outside of Respondent's network of providers.

IT IS THEREFORE ORDERED that

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



SK/tm

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

DHHS -Dept Contact

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]