[redacted]
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Date Mailed: September 10, 2020
MOAHR Docket No.: 20-004852
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on August 25, 2020. [redacted], Petitioner's father/legal guardian, appeared and testified on Petitioner's behalf. [redacted], Petitioner's mother, also testified as a witness for Petitioner. Leslie Garrisi, Access Center Supervisor, appeared and testified on behalf of the Respondent Macomb County Community Mental Health.

During the hearing, Petitioner's submitted documents that were admitted into the record as Exhibits A-H. Respondent also submitted an evidence packet that was admitted into the record as Exhibit #1.

ISSUE

Did Respondent properly deny Petitioner's request for reauthorization of her specialized residential treatment services?

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 with a legal guardian. (Exhibit H, pages 11-14; Exhibit #1, page 7).

2. She has been diagnosed with unspecified bipolar and related disorder; intermittent explosive disorder; and borderline intellectual functioning. (Exhibit B, page 3; Exhibit #1, page 31).

3. Her symptoms include physical violence toward others; destruction of property within the home; stealing; impaired hygiene; an inability to complete activities of daily living without assistance; poor interpersonal relationships; unpredictability; and depression. (Exhibit B, page 1; Exhibit #1, page 31).

4. Since the age of eighteen, Petitioner has resided in a group home or specialized residential home. (Exhibit #1, pages 7, 31).

5. In her current placement, Petitioner has been approved for specialized residential treatment services through Respondent. (Exhibit #1, pages 36-62).

6. Due to health and safety concerns arising from the COVID-19 pandemic, Petitioner's father/guardian removed her from her current placement on March 25, 2020. (Testimony of Petitioner's representative).

7. On May 13, 2020, Petitioner's Case Manager through Respondent completed an Annual Assessment with respect to Petitioner. (Exhibit #1, pages 7-33).

8. However, contrary to Respondent's usual practices, the Case Manager did not document who she spoke with while completing the assessment. (Testimony of Respondent's representative).

9. She also marked "Unknown" for sections regarding Predominant Communication Style, Ability to Make Self Understood, Support With Mobility, Mode of Nutritional Intake, Support With Personal Care, Relationships, Status of Family/Friend Support System, Support for Accommodating Challenging Behaviors, and Presence of a Behavior Plan. (Exhibit #1, pages 26-29).

10. The Annual Assessment did note that Petitioner had been staying at her father/guardian's house for the past two months. (Exhibit #1, page 17).

11. It also noted that Petitioner had not required any inpatient hospitalizations over the past year, but that she still requires assistance with personal care and a 24/7 supervised residential setting to both manage her symptoms or behaviors and for safety reasons, including her own safety as she is a vulnerable adult that could easily be taken advantage. (Exhibit #1, page 17).

12. Overall, the Annual Assessment concluded that Petitioner should maintain her current placement and services. (Exhibit #1, pages 17, 32).

13. On May 15, 2020, Petitioner's Case Manager also completed a LOCUS Assessment with respect to Petitioner and she scored Petitioner with a 24,

with a recommended disposition of “Level Five: Specialized Residential”. (Exhibit #1, page 34).

14. On May 18, 2020, Petitioner’s Case Manager further completed and signed a Person-Centered Plan (PCP) for Petitioner with respect to the upcoming plan year, *i.e.* May 17, 2020 through May 12, 2021. (Exhibit #1, pages 35-48).

15. The Case Manager also identified Petitioner and her guardian as having participated in PCP Meeting. (Exhibit #1, page 43).

16. However, Petitioner’s guardian denies participating in any meeting. (Testimony of Petitioner’s representative).

17. He also never signed a completed PCP. (Exhibit #1, page 48; Testimony of Petitioner’s representative; Testimony of Respondent’s representative).

18. Nevertheless, the goals and services to be approved in the PCP remained essentially the same from the year before. (Exhibit #1, pages 35-62).

19. A request for reauthorization of Petitioner’s services, including her specialized residential treatment services, was also subsequently submitted to Respondent. (Testimony of Respondent’s representative).

20. Petitioner returned to her current placement in June of 2020. (Testimony of Petitioner’s representative).

21. On June 1, 2020, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner’s specialized residential treatment services would only be approved through August 15, 2020. (Exhibit #1, pages 1-6).

22. With respect to the reason for the decision, the notice stated: “The documentation in the record no longer appears to support the medical necessity of specialized residential services.” (Exhibit #1, page 1).

23. On June 26, 2020, Petitioner requested a Local Appeal with Respondent regarding its decision. (Exhibit H, page 2).

24. On July 7, 2020, following an adjournment granted at Petitioner’s request, a Local Appeal Hearing was completed. (Exhibit H, page 2).

25. On July 27, 2020, a Local Appeals Coordinator for Respondent issued Findings and Recommendations in which she upheld Respondent’s action. (Exhibit H, pages 2-4).

26. On July 28, 2020, Respondent sent Petitioner a Notice of Appeal Denial stating that Petitioner’s appeal had been denied on the basis that the

available information did not support the need for Petitioner's current level of care. (Exhibit H, pages 5-10).

27. On August 3, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to Respondent's decision. (Exhibit #1, pages 1-14).

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, April 1, 2020 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *Page 10*

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.

Additionally, regarding personal care in a licensed specialized residential setting specifically, the MPM further states:

> **SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS**
>
> Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if 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. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.
>
> Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.
>
> **11.1 SERVICES**
>
> Personal care services include assisting the beneficiary to perform the following:
>
> - Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
> - Eating/feeding;
> - Toileting;
> - Bathing;

- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.

- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

MPM, April 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 78-79

Here, as discussed above, Respondent denied a request for reauthorization of specialized residential treatment services for Petitioner. Petitioner then appealed that decision.

In doing so, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information it had at the time the decision was made.

Given the record and applicable policies in this case, Petitioner has met that burden of proof and Respondent's decision must therefore be reversed.

Petitioner was previously approved for specialized residential treatment services pursuant to policies requiring that her services be provided in the least restrictive, most integrated setting that can meet her needs; and, while Respondent now finds that the documentation fails to support medical necessity for continuing with her past services, the record instead demonstrates that nothing significant has changed and that Respondent erred.

The undisputed fact that Petitioner was previously approved for the services at issue is not dispositive, but it is significant that Respondent cannot point to any changes in Petitioner's case that would warrant a change in her services.

Similarly, while Respondent does generally point to the documentation admitted into the record in support of its action, including the Annual Assessment, the LOCUS Assessment and the PCP, each of those documents expressly conclude that Petitioner's current services and placement should be reauthorized.

Moreover, to the extent Respondent relies on any specific findings in the Annual Assessment regarding Petitioner's personal care or behavioral needs, that reliance appears to be unwarranted given that it is undisputed that the assessment is incomplete in several significant aspects, including the identity of the source of the information for the assessment; Petitioner's supports with personal care; and Petitioner's support for accommodating challenging behaviors.

Accordingly, while the record may not establish that Petitioner meets the criteria for the requested services, it does demonstrate that Respondent erred when denying

reauthorization of Petitioner's specialized residential treatment services and that its decision to do so must be reversed at this time.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED** and it must initiate a reassessment of Petitioner's request for services.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
48913

Authorized Hearing Rep.

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DHHS-Location Contact

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