[redacted]
MI [redacted]

Date Mailed: July 15, 2021
MOAHR Docket No.: 21-002761
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 Appellant's request for a hearing.

After due notice, a hearing was held on July 7, 2021. [redacted] Petitioner's Brother and Legal Guardian appeared on behalf of Petitioner. [redacted], and [redacted], appeared as witnesses for Petitioner.

Angela Reamer, Clinical Supervisor, appeared on behalf of Respondent (Department). Lou Bersine, Supervisor, appeared as a witness for Department.

EXHIBITS

Petitioner: None

Respondent: None[1]

ISSUE

Did Department deny Petitioner's request to extend IPOS services an additional 9 months?

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 Medicaid beneficiary receiving services through the Department. (Testimony.)

[1] At no time prior to the hearing did Michigan Office of Administrative Hearings and Rules, receive a viewable copy of Respondent's proposed exhibit. Following the July 7, 2021, hearing, the Department sent MOAHR a viewable copy. The exhibit however was not reviewed or considered for purposes of this hearing as it was not timely filed/received.

2. In April of 2020, a substantiated recipient rights complaint was issued. The complaint found issues with the Department's ability to keep other residents and staff safe and secure due to Petitioner's behaviors. (Testimony.)

3. As a result of the substantiated recipient rights complaint, it was determined Petitioner could no longer be safely cared for in his current environment and a new placement was needed. (Testimony.)

4. Prior to April 21, 2021, an Individualized Plan of Service (IPOS) was created for Petitioner. The IPOS called for 3 months of continued Personal Care and Community Living Supports Services (CLS), while the Department found a new placement for Petitioner. After finding a new placement, a new IPOS would be developed to determine the appropriate level and scope of services. (Testimony.)

5. Prior to April 21, 2021, Petitioner requested the 3 months of continued care be extended for the rest of the IPOS year or an additional 9 months. (Testimony.)

6. On April 21, 2021, the Department issued Petitioner a negative action notice. The notice indicated Petitioner's request to extend the level of services was denied. (Testimony.)

7. Prior to April 27, 2021, Petitioner requested a local level appeal. (Request for Hearing).

8. On May 7, 2021, the Department issued a Notice of Appeal Denial. The notice indicated Petitioner's internal appeal was being denied. (Request for Hearing.)

9. On June 9, 2021, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing.

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.[2]
>
> 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.[3]

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…[4]

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 Michigan 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 MDHHS 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.[5]

The Department is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

---

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).
[5] 42 CFR 440.230.

The applicable sections of the Medicaid Provider Manual (MPM) provide:

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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- 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; 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.

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.[6]

The Department witnesses provided testimony indicating no services were terminated, suspended, or reduced and that the IPOS services in place for 3 months would be re-evaluated after Petitioner found a new placement.

Petitioner's Representative did not dispute that there were issues in the home and that Petitioner found himself in violent confrontations on one or more occasions and that Petitioner was likely aggravating to other residents. Petitioner's main argument was that Petitioner did not want to be moved "down-state" away from his family. That relocation, however, is not at issue for this hearing. There was no evidence of a "down-state" placement nor was there any such action notice asking/requesting the relocation.

Based on the evidence and testimony provided, it does not appear as if the Department violated any policies, laws, or rules pertaining to the Petitioner's receipt of benefits. If Petitioner were to 3 months down the line propose a reduction at the follow-up 3-month IPOS meeting, then Petitioner can most assuredly appeal that decision. Likewise, if/when the Department asks the Petitioner to move to a different location, the Petitioner

[6] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, April 1, 2021, pp 14-16.

can appeal that decision. At this time, it does not appear as if those issues are ripe yet for consideration.

As such, the Department's decision was proper and should be 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 Petitioner's request to extend IPOS services an additional 9 months outside the scope of the current IPOS.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/dh

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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
Petitioner	[redacted] MI
Authorized Hearing Rep.	[redacted] WA
DHHS Department Rep.	Mary Swift Pathways 200 West Spring St. Marquette, MI 49855