GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
DIRECTOR

[redacted]

Date Mailed: February 23, 2024
MOAHR Docket No.: 24-000710
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on February 22, 2024. [redacted] Petitioner's legal guardian, appeared and testified on Petitioner's behalf. Katie Forbes, Customer Care, appeared on behalf of Respondent, Regino 10 PIHP (Department). Dr. Tom Seilheimer, Chief Clinical Officer for Department; and Kathleen Gallagher, Program Director for St. Clair County Community Mental Health, appeared as witnesses for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did Respondent properly decide to terminate Petitioner's personal care and community living support (CLS) 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 Medicaid beneficiary who has been diagnosed with schizoaffective disorder (bipolar type), bilateral unspecified hearing loss,

severe cannabis use disorder, severe amphetamine-type substance use disorder, severe opioid use disorder, moderate inhalant use disorder. (Exhibit A).

2. On December 26, 2023, Petitioner underwent a resident assessment for reimbursement. The assessment indicated Petitioner was independent in the areas of eating, drinking, transferring, showering, dressing, bladder management, bowel management, ambulating, personal hygiene, turning and positioning, laundry, shopping, wearing appropriate clothing, securing and using transportation, using telephone, caring for personal possessions, writing correspondence, engaging in social and leisure activities; required prompting and cuing for managing healthcare and securing healthcare, along with making and keeping appointments. Petitioner required total assistance with managing finances. During the assessment, it was also determined Petitioner had no issues with orientation to time, place, and person, agitation, aggression, communication of needs, short-term memory, long-term memory and was able to safely use and/or avoid poisonous materials. Petitioner was determined to have minimal problems with judgment and hallucinations and moderate problems with understanding instructions. (Exhibit A; Testimony).

3. On December 27, 2023, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's request for CLS and personal care were denied as it was determined the services were no longer medically necessary. (Exhibit A; Testimony).

4. On January 3, 2024, Petitioner submitted to Department an internal appeal. (Exhibit A).

5. On January 17, 2024, the Department sent Petitioner a Notice of Appeal Denial. The notice indicated Petitioner's appeal was denied for the following reason:

> Based on the clinical evidence reviewed, medical necessity criteria is not met for Comprehensive Community Supports and Personal Care. There is documentation that you have achieved clinical stability objectives. Additionally, there is documentation of efforts to assist you to develop a transition plan into the community.[1]

6. On January 25, 2024, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Hearing File).

[1] Exhibit A, p 32.

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.[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

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.

> 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 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).

Here, as discussed above, Petitioner has been receiving covered Medicaid services through Department.

With respect to such covered services and the need for them, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **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

[4] 42 USC 1396n(b).

- 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.[5]

Similarly, with respect to personal care in licensed specialized residential settings, the MPM also provides in part:

> 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.
>
> **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

[5] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2024, pp 13-15

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 themselves by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).[6]

Here, as discussed above, the Department is terminating Petitioner's comprehensive community supports services as they determined Petitioner no longer met the medical necessity criteria due to Petitioner's current clinical symptomology. The Department indicated Petitioner's conditions have improved and stabilized, and that Petitioner recently underwent an assessment that determined Petitioner did not require assistance with any of the activities provided in a specialized residential setting.

While Petitioner disagreed with the conclusions reached and further provided several statements contradicting the Department's reasoning, the Petitioner failed to provide any documentation to corroborate their statements/arguments.

Consequently, I find sufficient evidence to affirm the Department's decision in this matter. However, based on the information shared, it appears Petitioner has experienced some decompensation since being discharged from the residential crisis center where he had been staying. This being the case, Petitioner is encouraged to submit a new request for services and provide the Department with information regarding Petitioner's deteriorating condition.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly decided to terminate Petitioner's comprehensive community supports services.

[6] *Id* at 90.

IT IS THEREFORE ORDERED that

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

CA/pe

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

Via Electronic Mail:

Petitioner

[redacted]

Authorized Hearing Representative

[redacted]

DHHS Department Contacts

Belinda Hawks
MDHHS
320 S. Walnut St., 5th Floor
Lansing, MI 48913
MDHHS-BHDDA-Hearing-Notices@michigan.gov
Hawskb@michigan.gov

Amanda Lopez
Lopeza24@michigan.gov

Phillip Kurdunowicz
Kurdunowiczp@michigan.gov

DHHS Department Representative

Erin Goodman - Region10 PIHP
3111 Electric Ave., Ste. A
Port Huron, MI 48060-5416
Goodman@region10pihp.org

DHHS Location Contact

Julie Palmer - Region 10 PIHP
2186 Water Street
Port Huron, MI 48069
Palmer@region10pihp.org