STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-11434 CMH
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of her son, [redacted] (Appellant). Also appearing as witnesses for the Appellant were [redacted] brother, [redacted] mother, and [redacted] sister-in-law.

[redacted], Fair Hearings Officer, appeared on behalf of the [redacted]), an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded mental health supports and services (hereafter, 'Department'). Also appearing as witnesses for the Department were [redacted] and [redacted], [redacted]

ISSUE

Has the Department appropriately terminated the Appellant's placement at [redacted], a licensed, residential in-patient treatment facility?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary with a developmental disability and severe emotional disturbance who is a recipient of services through the auspices of [redacted] as the Community Mental Health Services Provider (CMHSP). He has an Axis I primary diagnosis of Oppositional Defiant Disorder, secondary diagnosis of Mood Disorder NOS, and Axis II primary diagnosis of mild mental retardation. *(Exhibit 1, Attachment E)*

2. On [redacted], the Appellant presently began residing at the [redacted] in [redacted], with an original discharge date set for [redacted]. He remains at [redacted] pending a final decision in this matter. The Appellant also receives Community Living Supports (CLS), medication management, psychiatric services, personal care services, and therapy while housed at this location. *(Exhibit 1, Attachment A)*

3. On or about [redacted], through [redacted], the Appellant was admitted to [redacted]. Thereafter, the Appellant went to [redacted] in [redacted] on [redacted], and then hospitalized at [redacted] from on or about [redacted], through [redacted]. The Appellant was again screened by [redacted] on or about [redacted], and then admitted to [redacted] from or about [redacted], through [redacted]. *(Exhibit 1, Attachments B, C and O)*

4. The Appellant was again screened by [redacted] on or about [redacted], and admitted to [redacted] until [redacted]. The Appellant was again screened by [redacted] on or about [redacted], [redacted], and [redacted], without being admitted. [redacted] screened the Appellant on or about [redacted], and then admitted him to [redacted] until [redacted]. He was then transferred to [redacted] on [redacted], where he was discharged on or about [redacted]. *(Exhibit 1, Attachments B, C and O)*

5. On or about [redacted], and [redacted], [redacted] screened the Appellant without admitting him. On or about [redacted], through [redacted], the Appellant was admitted at the [redacted]. He was again screened by [redacted] on or about [redacted], and was admitted to [redacted] on or about [redacted], until [redacted]. On or about [redacted], the Appellant went to [redacted] and was not admitted. Lastly, the Appellant was screened at [redacted] on or about [redacted], and was admitted to [redacted] from on or about [redacted], through on or about [redacted], at which time he was admitted to [redacted]. *(Exhibit 1, Attachments B, C and O)*

6. The Appellant's behaviors, both past and present, include verbal and physical aggression, confirmed lying, property destruction, personal control, and inappropriate sexual behavior.

7. During the person-centered planning process on [redacted], the medical necessity of continued placement at [redacted] was evaluated. Additional mental health (B3) services were also considered at this time, to be implemented should the Appellant be returned to live with his mother and siblings.

8. The Appellant's [redacted], Person-Centered Plan provides for the following supports, once he is returned to the family home: *Family skill training with behavioral psychologist, 30 minutes, once weekly for three months; phone consultation with psychologist as needed between the hours of 9:00 AM-9:00 PM; CMS, 30 minutes once weekly for three months to support access to community resources; family therapy, 50 minutes once weekly for three months; development*

of a crisis plan by [redacted]; as needed access to crisis response team, 24 hour availability, seven days a week; CLS staff weekday mornings 6:00-7:30 AM, weekday evenings 3-10:00 PM and weekends 9:00 AM-9:00 PM, off school days will be scheduled 9:00 AM-9:00 PM initially; 2:1 coverage to be reviewed monthly; CLS staff training with behavioral psychologist, 30 minutes once weekly; CLS completed incident reports within 24 hours; CLS implement behavior plan in cooperation with client's mother daily; medication review by psychiatrist, 30 minutes, once monthly for three months; review of PCP once monthly. (Exhibit 1, Attachment D, page 3 of 3)

9. The Appellant's [redacted], Person-Centered Plan promotes as a goal community inclusion and participation, as he returns home, and to be maintained in the home setting without causing harm to either himself or others. *(Exhibit 1, Attachment D)* The Department has authorized the Appellant to receive in excess of 66 hours of CLS per week upon his return home, which is almost double the amount of CLS offered to the Appellant on prior occasions. *(Exhibit 1, Attachment H)*

10. The Appellant's [redacted], Person-Centered Plan also provides one to one staffing at home during his awake hours, psychologist services (training and phone consultations), weekly meetings, ongoing parental and staff training on behavioral plan and behavior management, therapy and case management services weekly, medication review by a psychiatrist monthly or as needed, medical services, development of a crisis plan, 24 hours a day, seven days a week access to Crisis Response team, respite available as needed, and occupational therapy as needed. *(Exhibit 1, Attachments D and H)*

11. A [redacted], with attached [redacted], letter, provides, in pertinent part as follows:

"..[redacted] is currently a resident at the [redacted] in [redacted]. He was admitted to this facility on [redacted] from [redacted]. He has a history of multiple psychiatric inpatient placements. His disruptive behaviors include physical aggression, verbal threats and property damage. His two recent home visits have not gone well. He exhibited physical and verbal aggression, as well as, property damage. He was returned early from these visits.

[redacted] are planning on moving [redacted] back to the home of his mother, [redacted]. She has consistently expressed the belief that [redacted] is not ready for this transition and is afraid for her own safety, as well as, the safety of her two daughters. She has appealed the decision to move [redacted] back to her home based on these concerns.

It is our professional opinion that while [redacted] has improved, he does

not demonstrate behavioral stability sufficient to allow him to transition back to the family home at this point in time. The risk of aggression and behavioral acting out on [redacted]s part remain likely.

Respectfully submitted,

[redacted]

(Exhibit 2)

12. On [redacted], the Appellant's mother filed her Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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.
>
> *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…

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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [redacted] contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

In addition to the criteria outlined in the Medicaid Provider Manual, the Code of Federal Regulations *42 CFR 440.230* states that Medicaid beneficiaries are only entitled to medically necessary **Medicaid-covered** services, provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

The Medicaid Provider Manual, Mental Health/Substance Abuse chapter provides a listing of the Medicaid covered services [redacted] may provide. With regard to "covered services," Section 3 states, in pertinent part, as follows:

> **Section 3 - Covered Services**
>
> The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services.

In determining whether to grant or deny the Appellant's requests, [redacted] must apply the Department's medical necessity criteria. The Department's policy for medical necessity is as

follows:

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. (Emphasis supplied by ALJ)*

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.

Medicaid Provider Manual, Mental Health/ Substance Abuse, Version Date: April 1, 2008; Section 2.5. Page 12-14.

Crisis Residential Services are Medicaid-covered services. The Medicaid Provider Manual, Mental Health/Substance Abuse chapter, details the eligibility requirements for this service:

Section 6 - Crisis Residential Services

Crisis residential services are intended to provide a *short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. (Emphasis added)* Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

Medicaid covered crisis residential services are not long-term services, but rather, short-term alternative placements available only to individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This service does not include room and board costs.

The evidence presented establishes the Appellant has been hospitalized on numerous occasions, all resulting in discharge following an amelioration and diminishment of behavioral

symptoms. The evidence further establishes the Appellant's behaviors have shown marked improvement in structured settings, and that, once discharged from these settings and released into the community, his behaviors decline to an extent that he requires inpatient hospitalization assessment, and, on some occasions, admission.

However, the [redacted] is designed as a short term alternative to formal inpatient psychiatric admission, not a long-term solution to ongoing behavioral challenges. The evidence presented indicates that the Appellant's behaviors have improved while he has resided at the [redacted], but that they have not been eliminated entirely. Thus, a conclusion may be drawn that the residential setting may not, in fact, be the best, most cost-effective, placement alternative for the Appellant at this particular time, because the residential setting has not, in fact, eliminated all undesirable behaviors.

To the contrary, [redacted] has provided credible evidence that, once the Appellant is discharged home, it has authorized a considerably more intensive array of services (e.g., increased CLS, psychiatric medication review and monitoring, one-to-one staffing during waking hours, etc). [redacted] witnesses testified that service authorization was increased, specifically due to the concerns of the Appellant's family that, once home, his behavioral outbursts would recur.

The Appellant's mother presented no evidence to suggest that the [redacted] authorization would not work under any circumstances, only that she feared for the safety of herself and her other children, if the Appellant were to return home. While this fear is more than justified, considering the history of this case, the fact remains that [redacted] has undertaken its best efforts to ensure that, once the Appellant is discharged home, he will be receiving comparable Medicaid-funded services that can safely be provided in his home in a more cost-effective manner.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that [redacted]'s proposed termination of crisis residential services at the [redacted] is appropriate at this time.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _____4/14/2009_____

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.