STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-46535 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted] appeared on his own behalf. [redacted], appeared with the Appellant. [redacted] represented the Department's agent [redacted] (CMH). [redacted]; [redacted], and [redacted], appeared on behalf of the CMH.

ISSUE

Was the CMH'S [redacted] decision to terminate Appellant's residential therapy center (RTC) service proper?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant was enrolled in [redacted] in [redacted].

3. Therapeutic support services offered in a residential setting are Medicaid-covered if offered on a short-term basis and to avoid inpatient hospitalization. (Exhibit G, Medicaid Provider Manual, Mental Health and Substance Section, section six, April 1, 2010, page 32).

4. In [redacted] the Appellant requested from CMH, residential therapy center

services to help him with his alcohol addiction and to avoid inpatient hospitalization. (Exhibits B, pages 4, 5).

5. In [redacted] CMH authorized residential therapy center services for Appellant on a short-term basis from [redacted], through [redacted]. (Exhibits B, pages 4, 5).

6. Appellant was receiving residential therapy center services through CMH's agent, [redacted], a 10-bed licensed care facility. (Exhibits A, G).

7. Less than a couple weeks after moving into the residential therapy center the Appellant moved out and went to live with a friend. (Exhibit B).

8. In [redacted] the Appellant returned to CMH and requested to again receive residential therapy center services. (Exhibit B).

9. Appellant's case manager appended the individual plan of service (IPOS), authorizing residential therapy center services from [redacted], through [redacted]. The Appellant's goals articulated in the appended plan were to avoid hospitalization via placement in the residential therapy center while assisting Appellant to interact in the community and link to community services. (Exhibit B, page 2).

10. During [redacted] the Appellant took eight leaves of absence for nonclinical reasons from the residential therapy center. (Exhibit D).

11. In [redacted] the Appellant's IPOS was reviewed and the CMH determined his residential therapy center was no longer medically necessary because he had met the goals of his IPOS. (Exhibit D).

12. A local level appeal was provided to the Appellant. Based on a review of the Appellant's documentation by an independent mental health professional the CMH affirmed its determination that residential therapy center services were no longer medically necessary for the Appellant. (Exhibit E).

13. On [redacted], the CMH sent an Advance Action Notice to the Appellant indicating that his residential therapy center services would be terminated, effective [redacted]. (Exhibit A).

14. The Appellant's request for hearing was received on [redacted], and a hearing scheduled for [redacted]. (Exhibit 1).

15. The Appellant has not had an inpatient hospital stay since [redacted]. (Attachment to Hearing Summary).

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 CLS 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 (CLS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Community Health to

provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Therapeutic support services offered in a residential setting are Medicaid-covered if offered on a short-term basis and to avoid inpatient hospitalization. *Medicaid Provider Manual, Mental Health and Substance Section, section six, April 1, 2010, page 32.* The CMH witness [redacted] testified that because residential therapy center services are paid for by Medicaid only if approved for a short term stay, CMH authorized Appellant's stays for short-term periods of three to four months. The CMH witness [redacted] testified that CMH authorized residential therapy center services for Appellant on a short-term basis from [redacted], through [redacted].

Witness [redacted] said that shortly after moving in the Appellant left the residential therapy center to live with a friend. Witness [redacted] explained that because the Appellant had intentionally moved out of the residential therapy center the services authorization ended. The CMH witness [redacted] explained that the Appellant returned to CMH claiming that he needed residential therapy center services to avoid drinking alcohol and a new individual plan of service was developed which authorized services from [redacted], through [redacted].

The CMH witness [redacted] testified that because the Appellant left the residential therapy center for overnight or longer on at least eight occasions in [redacted], it was determined that the goal articulated in his individual plan of service had been accomplished; the residential therapy center service was no longer medically necessary and would be terminated.

CMH witnesses testified that the Appellant was able to perform all his activities of daily living, was able to engage in the community and navigate the community on his own. It was noted that the Appellant was able to drive his own car in the community and that his needs could be met in an adult foster care setting, instead of a more intensive residential therapy center. Witness [redacted] testified that the Appellant stated the reason he wanted to stay at the therapeutic residential center was because he was comfortable there and he could save money to buy a house if he continued to live there.

The Appellant testified that he is still emotionally unstable. The Appellant testified that beginning in [redacted] he started having suicidal thoughts. The Appellant testified that an adult foster care situation would not work for him, because it gave him too much freedom to do the "things I do."

During the hearing, the CMH introduced evidence of the fact that Appellant was authorized for residential therapy center services for a short-term, four-month stay and had met the goals for that authorization. (Exhibits A, B, D, E).

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* states that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

2.5.B. MEDICAL NECESSITY 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2010, page 13.

The CMH evidence that Appellant had gone on at least eight leaves of absence in [redacted] and had returned after successful stays in the community, supports the CMH determination that the goals set for the Appellant in the four-month-authorization of residential therapy services had been achieved. The Appellant must prove by a preponderance of evidence that the CMH termination of residential therapy center services was not proper, but he did not meet that burden. The CMH provided credible evidence that its [redacted] termination of residential therapy center services was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH's termination of Appellant's residential therapy center services was proper.

Of IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/26/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.