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. 2010-43263 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], attorney, appeared on behalf of the Appellant. His witnesses included [redacted], Regional Director, [redacted] Social Worker, [redacted] and [redacted], Psychologist. [redacted], Fair Hearings Officer, represented the Department. Her witness was [redacted], [redacted] Director of Adult Services.

At the threshold of hearing the Department moved for dismissal owing to the State Office of Administrative Hearings and Rules (SOAHR) lack of jurisdiction as the Appellant had suffered no loss of services. The Department's objection was taken under advisement and testimony was heard by the ALJ.

ISSUE

Did the [redacted] Authority properly substitute Crisis Prevention Institute techniques for [redacted] techniques requiring seclusion and restraint in the treatment of the Appellant?

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 an [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. He is enrolled in [redacted]. (Appellant's Exhibit #1)

3. On [redacted] the Appellant was advised by adequate action notice that the provision of services consisting of seclusion and restraint would be substituted with the gradual protocols of CPI. (Department's Exhibit A, pp. 3, 4)

4. It is the position of the CMH that the utilization of restraint and seclusion under CLS is unlawful in Michigan. (Department's Exhibit A)

5. On [redacted] the Appellant was advised of his further appeal rights. (Department's Exhibit A, pp. 5, 6)

6. The notice did not identify and adverse actions or proposed adverse action relative the services and supports being provided to the beneficiary. (Department's Exhibit A)

7. The Appellant is afflicted with Autism, Intermittent Explosive Disorder, and Bipolar Disorder NOS. [Appellant's Exhibit 2, p. 1 and Department's Exhibit A –[Sub B, p. 10)]

8. The Appellant requires around the clock care and staffing. [See Testimony and (Department's Exhibit A – D)]

9. There is no dispute that the CMH is providing funding for caregivers. (Appellant's Exhibit #1)

10. The CMH maintains that they have provided – and continue to provide – services and supports to the beneficiary in an amount scope and duration sufficient for him to remain in the least restrictive environment without the use of prohibited seclusion and restraint methods. (Department's Exhibit A)

11. The instant appeal was received by the State Office of Administrative Hearings and Rules (SOAHR) on [redacted]. (Appellant's Exhibit #1)

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

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…

Section 1915(c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The Monroe County Community Mental Health Authority (CMH) contracts with the Michigan Department of Community Health to provide those services.

Medicaid beneficiaries are only 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.

The MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1 and Attachment 3.1.1, Section III(a) Access Standards-10/1/08, page 4, directs a CMH to the Department's Medicaid Provider Manual for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's Medicaid Provider Manual (MPM), Mental Health Chapter delineates the prohibition against seclusion and restraint as consistent with federal regulations in the development of a behavior treatment plan.[1]

***

The Department witness explained that the Appellant's guardians were simply sent an action notice even though no negative action had occurred. Translated into hours of service per the person centered plan and the resulting [unexecuted] Individual Plan of Service (IPOS) the Appellant is receiving his required, around the clock, care with multiple attendant staffing. There was no dispute from the Appellant that the number of hours of services and supports were inadequate, but rather that their desired plan - developed at [redacted] – was not fully implemented.[2]

After one year of treatment at [redacted] and pending discharge the [redacted] Authority ([redacted]) sent a representative to the university to learn the specifics of the Appellant's discharge planning on his prospective return to Michigan. The discharge plan was adopted in full – with the exception of procedures requiring restraint and seclusion of the Appellant in contravention to the Michigan Mental Health Code at MCL 330.1708, which states:

> [**Suitable services; treatment environment; setting; rights]**
>
> (1) A recipient shall receive mental health services suited to his or her condition.
>
> (2) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.
>
> (3) Mental health services shall be offered in the least restrictive setting that is appropriate and available.

[1] MPM, Mental Health [ ], §3.3, Behavior Treatment Plan, [redacted], at page 16
[2] *See* Appellant's Exhibit #1

> (4) A recipient has the right to be treated with dignity and respect. (Emphasis supplied)

In its place the MCCMH, following required [redacted] (Committee) review, substituted long standing techniques adopted from the [redacted] for the control of aggressive behavior which they claim to be more consistent with federal regulations, Michigan law, rules and Medicaid policy.

One obvious omission in the submission of proofs from the parties at hearing was failure to reference any accumulation of documentation on failed efforts which could lead to some version of physical management – within the confines of the Department's contractual agreement with the State of Michigan [attachment P.1.4.1] which guarantees local polices and protocols that ensure the least restrictive interventions for control of recipient behavior.

Clearly, the behavior management techniques sought by the Appellant under its proposed [redacted]r Institute [redacted]) plan constitutes prohibited physical management and prohibited seclusions – as well as prohibited restraint under the MCCMH contract, the various rules and the Mental Health Code.[3]

The contractual requirement under which the [redacted] [or any other PIHP] receives funding prohibits the utilization of seclusion and restraint techniques as physical management – even if consented to by the Appellant and/or the guardian.[4]

The Michigan Department of Community Health flatly prohibits its mental health agencies from participating in violence perpetrated on recipients of mental health services in the name of treatment – when other viable and gradual protocols exist.

The [redacted] calls for prohibited seclusion by placing the Appellant in an empty room, closing the door [as a signal] and monitoring him through a window for between 5 and 30 minutes – "until calm."

Under Michigan law seclusion is prohibited:

> ● "Seclusion" means the temporary placement of a recipient in a room, alone, where egress is prevented by any means.
>
> MCL 330.1700(j)

Clearly, the Appellant's ability to egress or leave the room is prevented because the people who placed him in the room are on the outside looking in and have likely used prohibited come-along techniques to ensure his placement in the "safe room." While there was much discussion about the Appellant being a 180-200 pound, healthy, 6 foot, [redacted] old male who suffers from autism, intermittent explosive disorder and Bipolar

[3] *See* MCLA 330,1708; 330. 740; 330.742; R 330.7199(2)(g); 42 CFR 438.100 *et seq* and the Medicaid Provider Manual (MPM) Mental Health [ ] chapter, generally.
[4] *See* MPM, Mental Health [ ] §3.3 Behavior Treatment Review, [redacted] at page 16.

Disorder NOS – there was no suggestion that he is catatonic or that he is incapable of understanding what awaits him on the other side of the door – if he decides to leave too soon. Far from being a signal - the closed door and placement prohibits his exit in a disturbingly Kafkaesque manner.

Under Michigan law physical management as an element of a plan of care is prohibited:

> ● ”Physical management” means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others. [R330.7001(m)] Physical management – part of the KKI plan of care is prohibited under Michigan law except in a defined emergency situation.
>
> Rule 330.7243(11) states: Physical management as defined in R330.7001(m) may only be used in situations when a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of serious or non-serious physical harm.
>
> Both of the following shall apply:
> (i) Physical management shall not be included as a component in a behavior treatment plan.
> (ii) Prone immobilization of a recipient for the purpose of behavior control is prohibited unless implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient's record.

In the KKI plan of care the Appellant is carried – using prohibited techniques – into his safe room for seclusion treatment following a single instance of aggression.

In order to protect the Appellant’s rights under MCL 330.1708 only lawful services may be used to treat the recipient. The services and supports recommended by the MCCMH call for use of CPI techniques – which graduate to increasing management when all else fails. The [redacted] position is that the gradual protocols of CPI have been proven successful over time, are gradual in nature and negate the routine application of emergency measures against the Appellant.

If the CPI gradual methodology does not succeed in calming an aggressive recipient, then armed with supporting documentation and appropriate peer reviewed medical literature, procedures may be changed by the Committee.

At present the Appellant is a long distance from reaching "last resort" status. However well intentioned the KKI plan might be, the [redacted] acts lawfully by discarding seclusion and restraint measures and substituting in their place the gradual protocol(s) espoused through the CPI.[5]

● Based on current law and policy it would therefore not be permissible to use seclusion or physical management in an individual care plan for community services solely because the technique espoused by its advocate is alleged to be more successful in controlling aggression than other permissible [redacted]H techniques. However, as a last resort with sufficient documentation and sufficient peer reviewed medical literature similar techniques might be utilized or approved following review by the relevant Committee.

The Medicaid federal regulations contain a threshold that a Medicaid beneficiary must reach in order to be entitled to an administrative hearing. This SOAHR only has jurisdiction to hear matters related to a denial, reduction, termination, or suspension of a Medicaid covered service. 42 CFR 431.200 et seq. and 42 CFR 438.400 *et seq.*

DECISION AND ORDER

Because the [redacted] Health Authority has not denied, reduced, terminated, or suspended a Medicaid covered service, and based upon the above findings of facts and conclusions of law the Administrative Law Judge decides that SOAHR lacks jurisdiction to resolve the Appellant's issue.

IT IS THEREFORE ORDERED that:

The petition is DISMISSED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[5] MDCH Mental Health [ ], Technical Requirement for Behavior Treatment Plan Review Committees, *Contract attachment* P.1.4.1. [redacted] states in part: … MDCH will not tolerate violence perpetrated on the recipients of public mental health services in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop a individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future [R330.7199(2)(g)] …

cc: [redacted]

Date Mailed: 10/19/2010

***** 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.