STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-50959 CMH
Case No. 13344470

Appellant
_____/

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 Wednesday, [redacted]. Appellant's mother, [redacted], and Appellant's grandmother, [redacted], appeared and provided testimony on behalf of the Appellant.

[redacted], Fair Hearing Officer, [redacted] County Community Mental Health Authority (CMH), represented the Department. [redacted], A, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for residential placement?

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] year old Medicaid beneficiary receiving services through Oakland County Community Mental Health (CMH).

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. The Appellant is diagnosed with PDD-NOS, ADHD, Mood Disorder NOS, Intermittent Explosive Disorder and mental retardation. (Exhibit 6).

4. The Appellant was recently returned home after being discharged from [redacted] Hospital. (Exhibit 2).

5. The Appellant is currently attending school at the [redacted] program in

[redacted]. (Exhibit 2)

6. The Appellant has been receiving services through [redacted] County CMH since [redacted]. Current authorized services include: Supports Coordination (up to 30 hours per month), Respite (hourly – 24 hours/day), Psychological Testing (Development of a Suicide Prevention Plan and the Behavior Support Plan), Health Services/Parent Education (Training for support staff regarding the Suicide Prevention Plan and the Behavior Support Plan), Treatment Planning, Family Therapy with Consumer Present, and medication review. The Appellant is receiving supports and services through Self Determination. (Exhibit 2).

7. Prior to Appellant's release from [redacted], Appellant's mother requested residential placement. (Exhibit A)

8. CMH denied the request for residential placement because it determined that such placement was not medically necessary and because there is no Medicaid Covered Specialty Mental Health Service or Support for minor children that covers long-term residential placement. (Exhibit 1)

9. On [redacted], the CMH sent a notice to the Appellant's mother notifying her that the request for residential placement was denied. (Exhibit 1). Appellant's mother completed a request for hearing on [redacted]. (Exhibit A)

10. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit A).

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 of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

[redacted], Assistant Director at Community Living Services, Inc., the contractor providing services for Appellant, testified that to ensure Appellant's safety, and the safety of those around him, the Department approved 24 hour/7 day-per week supports. [redacted] testified that the Department must apply the Medical Necessity criteria

from the Medicaid Provider Manual and that this criteria includes provisions designed to promote community inclusion and participation. Ms. Lindstrom testified that she believes that the services provided are appropriate in scope, duration, and intensity to achieve the purpose of the services.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Sections 2.5.C and 2.5.D provide*:

> **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. (Emphasis added)
>
> **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. (Emphasis added)
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Program Requirements Section, July 1, 2011, pages 13-14.*

The Appellant's mother testified that Appellant's problems have been ongoing for many years, but that they have gotten worse since the death of Appellant's grandmother in [redacted]. The Appellant's mother indicated that since Appellant was released from the [redacted] Hospital on [redacted], the staff has already begun to become frustrated in dealing with him. She testified that Appellant usually does the opposite of what she asks and that he can fly into a rage with no known provocation. Appellant's mother also testified that she has been frustrated with the staff assigned to work with Appellant because they will not give her information regarding who is coming and when they will be coming. Appellant's mother indicated that this uncertainty makes it difficult to have the stability and structure in the home that Appellant needs. Appellant's mother also testified that Appellant seems happier when hospitalized and, even though he indicates he wants to come home while hospitalized, he will want to return to the hospital within a few days of being home. Appellant's mother indicated that she is overwhelmed and does not believe she can properly care for Appellant in his current state. Appellant's mother indicated that she fears for the safety of Appellant, as well as her own safety and that of her 3 year old child, who also lives in the home.

Under the Department's medical necessity criteria section, there exists a more clinically appropriate, less restrictive and more integrated setting in the community for Appellant, specifically his own home. Clearly, Appellant's placement in his own home is less restrictive than any residential placement. Furthermore, as noted above, "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." Here, Appellant had only been in his home for 6-7 days at the time of the hearing and, while there have clearly been some difficulties, it cannot be said at this time, that this less restrictive level of treatment has been unsuccessful. More importantly, based on the Department's covered services policy, long-term residential placement is not a Medicaid covered service. As [redacted] explained, it will be very difficult for Appellant to learn how to act at home if he is institutionalized.

The Appellant bears the burden of proving by a preponderance of the evidence that residential placement is a covered service and is a medical necessity in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden to establish that such placement is a Medicaid covered service or is a medical necessity.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for residential placement.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **9/15/2011**

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.