

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

██████████

Appellant

_____ /

Docket No. 2013-40679 CMH

██████████

██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.* and upon the request for a hearing filed on behalf of Appellant/Petitioner.

After due notice, a hearing was held on ██████████ Appellant's mother appeared and testified for the Appellant. Ms. ██████████ Due Process Manager for ██████████ (formerly ██████████ Community Mental Health), (CMH), represented the Department (MDCH). Ms. ██████████ LMSW, CMH Utilization Management Coordinator appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request 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. Appellant is a ██████-year-old female (██████████) who has been diagnosed with Autism. (Exhibit A, pp.1, 33, 53, and testimony).
2. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH's service area.
3. Appellant is authorized to receive Medicaid covered Specialty Mental Health services as a person with a developmental disability from the CMH of Targeted Case Management, Therapy, Medication Clinic services, and Respite. (Exhibit A, Hearing Summary and p. 30).

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4. On [REDACTED] a written request was submitted on behalf of the Appellant to the Utilization Management Department for CMH for authorization of residential placement in the [REDACTED] program a licensed Child Caring Institution in [REDACTED] (Exhibit A, pp. 1-5).
5. On [REDACTED] CMH sent Appellant written notice stating that the request for residential placement was denied. The reason given in the notice: "Residential services are not covered under your current benefit package. Other mental health services need to be explored during the Person Centered Planning process." (Exhibit A, pp. 6-8).
6. The Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed on behalf of Appellant on [REDACTED]

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

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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.]

Moreover, 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.

In this case, CMH notes that, while Appellant's family is requesting that she be placed in a Child Caring Institutions (CCI), the Medicaid Provider Manual (MPM) only covers services provided in CCIs. The costs of room and board are not covered by Medicaid. The MPM provides the following:

2.3 LOCATION OF SERVICE

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

* * *

Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions

(CCI) unless it is for the purpose of transitioning a child out of an institutional setting (CCI).

* * *

Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities). [MPM, October 1, 2012 version, Mental Health and Substance Abuse Chapter, Section 2.3 (emphasis added).]

The January 1, 2013 version of the Michigan Medicaid Provider Manual (MPM), Mental Health and Substance Abuse Chapter, Sections 2.5.C and 2.5.D provides in part:

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

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- 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]

The January 1, 2013 version of the Michigan Medicaid Provider Manual (MPM), Mental Health and Substance Abuse Chapter, Section 17 provides in part:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically

necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain. [pp. 110, emphasis added].

17.3.G. HOUSING ASSISTANCE

Housing assistance is assistance with short-term, interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance.

Additional criteria for housing assistance:

- The beneficiary must have in his individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and

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- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs.
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.
- Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary. [p. 119].

██████████, LMSW, stated she was the CMH Utilization Management Coordinator who reviewed the Appellant's request for residential placement in the ██████████ program. Ms. ██████████ stated she reviewed the request received from the Appellant's case manager at ██████████ and also looked on the Internet to determine that the ██████████ program was a residential based treatment program for individuals with

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Autism. Ms. [REDACTED] stated that based on the Appellant's clinical records she might be a fit for the [REDACTED] program. Ms. [REDACTED] stated she looked at the Medicaid benefit package available to the Appellant as a developmentally disabled child receiving mental health services. Ms. [REDACTED] stated she determined that residential placement was not covered under the Medicaid Manual for the Appellant. Ms. [REDACTED] also acknowledged there were a number of references in the Medicaid Provider Manual that state in general the costs of room and board are not a Medicaid covered service. (See Exhibit A, pp. 16-21).

Ms. [REDACTED] stated on [REDACTED] she sent Appellant's mother an Adequate Action Notice denying placement in the D.A.R.T program because residential services were not covered under Appellant's benefit package and other mental health services needed to be explored during the person centered planning process. Ms. [REDACTED] noted the table of contents for Mental Health Services did not list residential placement as a covered service. She further stated under the B-3 services room and board is not a covered service, which is equivalent to a request for residential placement.

Ms. [REDACTED] stated residential placement would also not be the least restrictive and cost effective treatment option available to the Appellant at this point. She stated there were other available services that could be provided to the Appellant and her family that had not yet been provided, including Community Living Supports, which are supports and services which could come into the Appellant's home with staffing. Ms. [REDACTED] stated in Appellant's case services could include having a psychologist come into the home, having a behavior plan, having support staff come in to train on the behavior plan and to support the family, and continuing with respite services to provide some relief for the Appellant's mother. Ms. [REDACTED] stated there were additional services that could be based in the community which would better serve the Appellant and her family that had not been previously tried with the family. She further stated that in her professional opinion, the Appellant would benefit from additional services that CMH could offer her in her home at this time.

Appellant's mother testified the Appellant has been disabled since she was two and a half years old. She has done her best to care for the Appellant who engages in both aggressive and self-injurious behaviors of pinching and bruising herself. Appellant's mother stated Appellant needs Occupational Therapy services. She stated the [REDACTED] program was recommended by [REDACTED] and she thinks the program would be of great help to the Appellant and her family. Appellant's mother believes the Appellant is a perfect candidate for the [REDACTED] program. Appellant's mother says that Appellant desperately needs help and she currently has no services in the home. She said Appellant needs structure and thinks OT services would help. Appellant's mother acknowledged that the Appellant does attend school at [REDACTED] in special education.

Based on the evidence submitted by Respondent regarding the [REDACTED] program (Exhibit A, pp. 1-5), it does appear that the facility is a CCI that serves children with

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developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. In any event, the requested residential placement is not a covered service under Medicaid in general. The cost for placement at ██████████ is billed on a per diem basis, which includes room and board. Since the relevant Medicaid policy does not allow for payment of room and board, rather only Medicaid covered services provided in a CCI for which individuals are eligible, CMH was correct in denying Appellant's request for services. 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.

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 her own home. Clearly, Appellant's placement in her 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, there are other available services that could be provided to the Appellant and her family that had not yet been provided, including Community Living Supports, which are supports and services that could come into the Appellant's home with staffing. These additional services could be based in the community which would better serve the Appellant and her family, and in the CMH Utilization Management Coordinator's professional opinion, the Appellant would benefit from the additional services that CMH could offer her in her home. Therefore, it cannot be said at this time that this less restrictive level of treatment would be unsuccessful. The MPM still requires that services be provided in the least restrictive, most integrated setting possible and until a less restrictive level of services proves unsuccessful, a more restrictive level of services, such as a placement at the ██████████ program cannot even be considered.

The Appellant bears the burden of proving by a preponderance of the evidence that the requested residential placement is both a covered service in this case and is medical necessary in accordance with the Code of Federal Regulations. Here, Appellant did not meet the burden to establish that such placement was a medical necessity at the time the decision was made and the CMH's decision must therefore be affirmed.

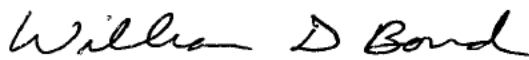
DECISION AND ORDER

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


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IT IS THEREFORE ORDERED that:

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



William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: 

Date Mailed: 

WDB/db

cc: 

***** 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.