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) 373-4147

IN THE MATTER OF:

Docket No. 2013-44407 CMH

[redacted]

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 [redacted] Appellant's mother, appeared and testified on Appellant's behalf.

Attorney [redacted], Due Process Hearing Coordinator for [redacted] County [redacted] (CMH) represented the CMH. [redacted], Director of Children and Family Services, [redacted]), [redacted] Supervisor of Social Work Team for [redacted], and [redacted] Compliance Coordinator for [redacted] appeared as witnesses 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 a [redacted]-year-old Medicaid beneficiary, DOB: [redacted] Appellant was Medicaid eligible and received Support Coordination Services, and Community Living Supports (CLS) and Respite Care on a self determination basis through [redacted]) a contractual provider for CMH. (Exhibit A, pp. 2, and testimony).

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. Appellant has been diagnosed as a child with a developmental disability. Her diagnoses include: Bipolar disorder, mood disorder, infantile autism-active, manic-depressive, NOS, moderate mental retardation, seasonal affective

disorder, PMDD, anxiety disorder, and obsessive compulsive disorder. (Exhibit A, pp. 10, 12 and testimony).

4. Appellant currently lives in the family home with her mother and her mother's fiancée. Appellant participates in home schooling twice a week through [redacted]. (Exhibit A, p. 10 and testimony).

5. On [redacted], [redacted] sent an Adequate Action Notice to the Appellant's mother notifying her that her request for residential placement was denied effective [redacted] as the Appellant's needs can be met in a less restrictive setting. The notice included rights to a Medicaid fair hearing. [redacted] supported the decision by [redacted] to deny residential placement. (Exhibit A, pp. 4-5).

6. MAHS received Appellant's request for a hearing on [redacted] (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].
>
> 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] testified she was the Director of Child and Family Services for [redacted]. She stated she has a Master's Degree in School and Community Psychology, and a PhD in Clinical Psychology and a minor in Neuropsychology. [redacted] stated she has clinical background in treating children and in early intervention with children. She also stated she has experience with providing in-home therapeutic treatment for children living at home, behavioral treatment planning, and clinical diagnosis and assessment.

[redacted] stated she reviewed the Appellant's case file, including the psychosocial assessment completed by the Appellant's Supports Coordinator. [redacted] stated the Appellant has a history of verbal aggression, physical aggression, and some property destruction. [redacted] stated the Appellant has been given diagnoses of autism, mood disorder, and moderate mental retardation. She stated there is a person centered plan and a plan of service in place that provides CMH supports and services to the Appellant and her family. [redacted] stated the family was also seeking psychiatric services through a private psychiatrist.

[redacted] stated in her professional opinion that supports and services authorized through CMH were sufficient to meet the Appellant's needs in the community at this time. [redacted] noted there were some problems with frequency of services and follow through with the Appellant's services. For example, they are concerned with the psychiatric stabilization of the Appellant, and according to the Appellant's records, she has not seen her private treating psychiatrist in over a year.

[redacted] stated she was the Supervisor for the Social Work Team for [redacted] Children and Family Services. She stated she has a Master's Degree in Social Work and is a Licensed Masters Social Worker. [redacted] stated she also reviewed the Appellant's file. She stated she supervises the Appellant's Supports Coordinator. [redacted] stated the Appellant presents with some very challenging behaviors; she is diagnosed with autism, and has a difficult time regulating her emotions. [redacted] stated the Appellant is currently authorized to receive Medicaid covered services through self determination including [redacted] hours per week of Community Living Supports (CLS), [redacted] hours per week of respite care, and 12 overnight respites per year. [redacted] stated Appellant currently has only one approved caregiver, but with the approval of an additional caregiver, the CLS hours would be increased to [redacted] hours per week. [redacted] stated the Medicaid covered services are approved from [redacted] through [redacted]

[redacted] stated at the time of the denial in this matter Appellant was Medicaid eligible. However, as of [redacted] her Medicaid was suspended pending an approval for reauthorization. [redacted] stated Appellant is currently covered by private insurance a [redacted] insurance plan. [redacted] stated Appellant must exhaust her private medical coverage before receiving Medicaid coverage as Medicaid is the payer of last resort. She further stated the Appellant has not used all CLS hours authorized for the past several months. Appellant only used [redacted] hours in [redacted] hours in [redacted], and only [redacted] hours so far in [redacted]

[redacted] testified she was the Compliance Coordinator for [redacted]. She stated she has been a registered nurse for over [redacted] years and has a clinical background. [redacted] testified she manages all grievances and appeals received by [redacted]. [redacted] stated Appellant was Medicaid eligible at the time of her appeal; however, her Medicaid lapsed as of [redacted]. She stated Appellant's private insurance a plan through [redacted] is now in place. Appellant's [redacted] plan includes a comprehensive Autism rider; that includes coverage for autism spectrum disorder therapy, a multiple disciplinary assessment, and treatment for an autism spectrum disorder, including applied behavior analysis, and all other medically appropriate visits, including for comorbid conditions and diseases. [redacted] stated that the Appellant's mother has not accessed the autism rider to cover any services for the Appellant.

[redacted] stated Appellant has been authorized [redacted] CLS hours per week, [redacted] hours of respite care per week, and [redacted] overnight respites during the year. She stated Appellant's records show inconsistent staffing due to the Appellant's challenging behaviors. [redacted] stated Appellant's mother is the employer on the self determination arrangement and she been unable to maintain consistent staffing for the Appellant. [redacted] opined that the inability to maintain consistent staffing would likely have a negative impact on the Appellant's success or her ability to move forward, as well as, her relationship with her mother. [redacted] stated with an appropriate evaluation of the Appellant's behavior and consistent care services they should be able to successfully treat the Appellant in the community. She stated [redacted] would consider residential placement in the event that consistent community based services are proven unsuccessful in treating the Appellant's condition.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Section 2.3 provides*:

> **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.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. 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 home.
>
> For beneficiaries residing in nursing facilities, only the following clinic services may be provided:
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> - Nursing facility mental health monitoring;
> - Psychiatric evaluation;
> - Psychological testing, and other assessments;
> - Treatment planning;
> - Individual therapy, including behavioral services;
> - Crisis intervention; and
> - Services provided at enrolled day program sites.
>
> Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.
>
> Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. 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). The

following mental health services initiated by the PIHP (the case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI. This should occur up to 60 days prior to the anticipated discharge from a CCI.
- Wraparound planning or case management. This should occur up to 60 days prior to discharge from a 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). (Emphasis added).

Medicaid Provider Manual, Mental Health and Substance Abuse, Program Requirements Section, January 1, 2013, pp. 9-10.

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

- 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

- 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].

Appellant's mother testified she wanted to focus on the Appellant's behavior. Appellant's mother stated Appellant can be trained when she is exhibiting good behavior. However, she indicated the Appellant displays violent aggressive behavior and can go into a violent rage. Appellant's mother indicated Appellant's bad behavior can continue for several weeks at a time. She indicated when the Appellant gets like that she cannot be taken out into the community and cannot benefit from services provided in the community. Appellant's mother stated she wants the Appellant to be evaluated for her violent aggressive behavior, and wants her to receive help commensurate with this behavior.

Appellant's mother indicated she has requested placement in [redacted] Developmental Adolescent Residential Treatment program (D.A.R.T). Appellant's mother believes the D.A.R.T. program is a program designed for adolescents who have diagnoses and behavior similar to that of the Appellant. Appellant's mother wants CMH to authorize a residential placement at D.A.R.T. for the Appellant as she believes they specialize in dealing with and treating the types of behaviors exhibited by the Appellant. Appellant's mother does not believe the Appellant can get the help she needs with at-home services through CMH.

The relevant policy from the Medicaid Provider Manual establishes that Medicaid does not cover residential services provided to children with a serious emotional disturbance in a Child Caring Institution unless it is for the purpose of transitioning a child out of an institutional setting (CCI). The policy further provides that 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. The remainder of the cited policy makes it clear that Medicaid does not pay for the costs of on-going housing in a residential placement. In short the Medicaid will not cover the costs of housing for a residential placement, but may be able to provide services in a CCI if other less restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual.

The Appellant bears the burden of proving by a preponderance of the evidence that she meets the criteria for services in a residential placement in accordance with the Code of Federal Regulations (CFR). Appellant has not met this burden to establish that she meets the criteria for such a placement. CMH has shown that there are services available in the community which they believe in their professional opinions can assist the Appellant and her family in dealing with mental health and related behavioral problems. The Appellant's records show that there has been an inconsistent use of the previously authorized services and there has been no showing that consistent least restrictive arrangements have been demonstrated to be unsuccessful for the Appellant. A more drastic step of removing the Appellant from the family home should not be taken until a less restrictive alternative is given the chance to succeed.

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.

William D Bond

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

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]
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WDB/db

cc: [redacted]

***** 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.