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:

[redacted]

Docket No. 14-006123 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], Appellant's guardian, appeared on Appellant's behalf. Appellant also appeared and testified as did her mother, [redacted].

[redacted], Fair Hearing Officer, represented Respondent, [redacted] Community Mental Health Authority (CMH or Department). [redacted], Assertive Community Treatment (ACT) Program Team Leader; [redacted], ACT Case Manager Specialist; and [redacted], ACT Operations Manager, appeared as witnesses for the Department.

ISSUE

Did the CMH properly deny Appellant's request for residential placement at InterActions Residential Treatment Program (InterActions) at [redacted] in [redacted], Michigan?

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 [redacted] year old Medicaid beneficiary, born [redacted], receiving services through [redacted] Community Mental Health Authority (CMH). (Exhibit A, Attachment A, p 1; 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. (Exhibit A, Attachment A; Testimony)

3. Appellant is diagnosed with bipolar disorder, alcohol abuse in remission, and polysubstance dependence. (Exhibit A, Attachment A, p 5; Testimony).

4. Appellant has a history of high risk behaviors due to her mental illness and substance abuse disorder. (Exhibit A, Attachment A, p 2; Testimony).

5. Appellant currently resides in a specialized AFC home, where she has some restrictions due to her past behaviors. (Exhibit A, Attachment A, p 3; Testimony).

6. On [redacted], Appellant's ACT Case Manager discussed with Appellant the possibility of placement in the InterActions Residential Treatment Program (InterActions) at [redacted] in [redacted], Michigan. (Exhibit A, Attachment C; Testimony).

7. InterActions is a secured (locked) residential treatment facility for adults with chronic and persistent mental illness and the facility also treats those who are dually diagnosed with mental illness and substance abuse issues. (Exhibit A, Attachment E; Testimony)

8. On [redacted], Appellant met with a representative of InterActions at the CMH office in [redacted], Michigan. At the time of the meeting, Appellant indicated a desire to go into the program. (Exhibit A, Attachments D, F; Testimony)

9. On [redacted], Appellant was informed that she had been accepted into the InterActions program, but she indicated that she no longer wanted to go. (Exhibit A, Attachment G; Testimony)

10. On [redacted], Appellant reiterated to her ACT Team Leader that she did not want to go to InterActions. (Exhibit A, Attachment H; Testimony)

11. A [redacted] progress note completed by Appellant's ACT Case Manager also indicates that Appellant did not want to go to InterActions at that time. (Exhibit A, Attachment I; Testimony)

12. On [redacted], Appellant informed her ACT Team Leader that she did not want to move from her current residence at the present time, but might want to try something else in a couple of years. (Exhibit A, Attachment J; Testimony)

13. On [redacted] the ACT team discussed having Appellant go to InterActions on a trial basis. Appellant's mother and guardian strongly supported the opportunity for Appellant. Appellant's guardian wanted to make sure the CMH would pay for InterActions before Appellant was sent for a trial visit. (Exhibit A, Attachment K; Testimony)

14. Discussions amongst the ACT team and with Appellant regarding Appellant attending InterActions continued on [redacted], [redacted] and [redacted]. Discussions amongst the ACT team included whether Appellant would meet medical necessity criteria for the program. (Exhibit A, Attachments L, L-1, L-2; Testimony)

15. On [redacted], Appellant's ACT Team Leader met with Appellant's mother and guardian to discuss ACT staff concerns regarding Appellant being placed at InterActions given that InterActions is a more restrictive (locked) facility and would be difficult to justify given Appellant's improvements in targeted behaviors. (Exhibit A, Attachment M; Testimony)

16. On [redacted], the ACT Operations Manager spoke to Appellant's mother and guardian regarding InterActions, as well as other alternatives that could be tried if it was determined that InterActions did not meet medical necessity criteria. (Exhibit A, Attachment N; Testimony)

17. On [redacted], Appellant's ACT Case Manger met with Appellant. Appellant indicated during this meeting that she definitely did not want to go to InterActions. (Exhibit A, Attachment O; Testimony)

18. On [redacted], CMH sent Appellant's guardian an Adequate Action Notice indicating that the request to send Appellant to InterActions had been denied. (Exhibit A, Attachment P; Testimony)

19. Appellant's Request for Hearing was received by the Michigan Administrative Hearing System 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.*

The Medicaid Provider Manual provides, in pertinent part:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
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> 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**
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> 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.
>
> **SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM**
>
> Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. Michigan adopted a modified ACT model in the 1980's tailored to Michigan service needs. While a PIHP is free to use either the Michigan ACT model or the federal Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model, with prior Department approval, the use of the Michigan model is strongly encouraged.
>
> ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance

with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team.

All ACT team staff must have a basic knowledge of ACT programs and principles acquired through MDCH approved ACT specific training within six months of hire, and then at least one MDCH approved ACT specific training annually.

* * * *

4.3 ESSENTIAL ELEMENTS

Team-Based Service Delivery

ACT is a team-based service that includes shared service delivery responsibility that provides consistent continuity of care. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. ACT teams are expected to address co-occurring substance use disorders of beneficiaries within the team service. Providers of ACT services who also provide substance abuse treatment must have a substance abuse treatment license with the additional integrated treatment service category.

Team meetings occur Monday through Friday and are attended by all staff members on duty. The status of all beneficiaries is briefly reviewed. Documentation of daily team meetings includes all beneficiaries discussed and all staff members present. The daily schedule is organized and contacts scheduled.

* * * *

4.5 ELIGIBILITY CRITERIA

Intensity of Service

ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or

preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.

- The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment.

- The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.

- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

- Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.

- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

* * * *

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.

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
April 1, 2014, pp 111, 24-28, 12-14

CMH's ACT Team Leader, Case Manager, and Operations Manager testified regarding their interactions with Appellant, Appellant's guardian and Appellant's mother regarding the Interactions Program, as outlined in the above findings of fact.

Appellant's mother testified that Appellant is [redacted] years old and very smart, yet at her current residence all she does is sit around all day smoking cigarettes and drinking coffee or pop. Appellant's mother indicated that Appellant doesn't like change, so it is not surprising that she has vacillated so much about going to InterActions. Appellant's mother testified that Appellant has huge potential that is not being met. Appellant's mother indicated that ACT staff meet with Appellant maybe once per week for about 10

minutes and that Appellant could do so much more if given the tools. Appellant's mother testified that they are not focused on the lockdown portion of InterActions, but rather the fact that the program could help Appellant regain some of her independence and reach some of her potential. Appellant's mother indicated that at her current AFC home, Appellant is the highest functioning person there and it is very frustrating for her. Appellant's mother also indicated that there are parolees that live right next door and that Appellant may have had some problems with them. Appellant's mother testified that she knows Appellant can do so much more. Appellant's mother also indicated that she does not believe Appellant has improved that much recently.

Appellant's guardian testified that she agrees with the testimony of Appellant's mother. Appellant's guardian indicated that Appellant first has to learn to live in a more restrictive setting before she can learn to live in a less restrictive setting. Appellant's guardian testified that Appellant needs goals and something to work towards. Appellant's guardian testified that she wants Appellant to try InterActions even though she knows it will be scary for Appellant to leave [redacted]. Appellant's guardian testified that InterActions is a behavioral treatment facility and currently Appellant is not receiving many behavioral services.

Appellant testified that she feels like she is doing very well. Appellant indicated that she is scared that she will get herself into the wrong situation with the wrong people.

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 the AFC home where she currently resides. The InterActions program is a locked residential treatment facility, so it is clearly more restrictive than Appellant's current AFC home. Also, the clinical evidence presented at the hearing demonstrates that Appellant has shown improvement in the behaviors being targeted, so it cannot be said that the current living arrangement and ACT program are not meeting Appellant's needs.

It is clear that Appellant may need some additional behavioral services, and the CMH has offered a wide variety of such services in place of InterActions. The parties further discussed some of these options at the hearing and the undersigned would encourage the parties to further pursue these options.

Appellant bears the burden of proving by a preponderance of the evidence that residential placement at InterActions is a medical necessity in accordance with the Code of Federal Regulations (CFR) and Michigan Medicaid policy. Appellant did not meet the burden to establish that such placement 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 James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

RJM/skb

Date Signed: [redacted]

Date Mailed: [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.