

**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. 2014-20608 CMH

██████████
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 ██████████. Appellant appeared and testified on his own behalf.

██████████, Assistant Corporation Counsel, ██████████ (CMH), represented the Department. ██████████, MSW, LMSW, CADC, Director of the ██████████ for CMH appeared as a witness for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for Adult 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 ██████-year-old Medicaid beneficiary, DOB: ██████/██████ Appellant is authorized to receive Assertive Community Treatment/Integrated Dual Diagnosis Treatment for his diagnoses of bipolar disorder, opioid dependence, nicotine dependence, personality disorder, and hepatitis C. (Exhibit A, pp. 1-2, 10, 20, 29, 30-31, 49, 50, 59 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. On ██████████ CMH Access Center sent an Adequate Action Notice to the Appellant notifying him that his request for Adult residential placement in the Portable Supports Program was denied effective ██████████ because he did not meet the criteria for residential placement. The notice included rights to a Medicaid fair hearing. (Exhibit A, pp. 6, 29).

4. MAHS received Appellant's request for a hearing on ██████████. (Exhibit A, p. 8).

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.

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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 Director of the CMH ██████████ ██████████ testified Appellant is a ██████████ year-old who has been diagnosed with bi-polar disorder, opioid dependence, nicotine dependence, personality disorder, and hepatitis C. ██████████ stated Appellant has a history of high inpatient use of hospitalization. ██████████ stated the Appellant has been non-compliant with medication and outpatient therapy. ██████████ stated according to the Medicaid Provider manual the CMH can deny requested services if there is a less restrictive alternative that still meets the medical necessity requirements.

██████████ stated the CMH has an Adult Residential review team that reviewed the Appellant's request for the Portable Supports Program. It was determined the Appellant did not meet the criteria for that level of care. The review team recommended that the Appellant work with the ACT Team and meet with the housing coordinator who will assist with finding the Appellant suitable housing. ██████████ stated the Assertive Community Treatment (ACT) Dual Diagnosis Team is targeted to meet the specific needs of individuals such as the Appellant who have a dual diagnosis of a mental illness and a substance abuse history. She stated the ACT program would be tailored more to meet the needs of the Appellant than the requested residential services. ██████████ stated the ACT Team will assist the Appellant with locating housing. The ACT program is a multi-disciplinary program that provides more intensive treatment in the community, and the ACT Team will meet with the Appellant in his residence up to twice a day if necessary to insure that the Appellant is receiving the necessary mental health treatment. ██████████ stated in her professional opinion the placement in the ACT program is more appropriate for the Appellant than the Portable Supports Program and is provided in the least restrictive environment.

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

2.3 LOCATION OF SERVICE [Change Made 10/1/13]

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

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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:

- 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) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or **(revised 10/1/13)**. 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, October 1, 2013, pp. 9-10*].

The October 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 October 1, 2013 version of the Michigan Medicaid Provider Manual (MPM), Mental Health and Substance Abuse Chapter, Section 4 provides in part:

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.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDCH and meet the program components outlined below. Provider programs with more than one ACT team must be approved and registered separately. ACT teams are subject to Department re-approval every three years.

4.2 TARGET POPULATION

ACT services are targeted to beneficiaries who are diagnosed with serious mental illness, which may include personality disorders, who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.

- Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication adherence.
- Beneficiaries with serious mental illness with a co-occurring substance disorder.
- Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.
- Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
- Older beneficiaries with serious mental illness with complex medical/medication conditions. [p. 24]

4.5 ELIGIBILITY CRITERIA

Utilization of ACT services in high acuity conditions/situations allows beneficiaries to remain in their community residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition. Services include availability of multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multidisciplinary team which includes psychiatric and skilled medical staff. [p. 27-28].

[REDACTED]

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Appellant testified he is confused about the ACT Program and how it works. He stated he thought the Portable Supports Program was more suited to his needs. Appellant stated he has been hospitalized [REDACTED] or [REDACTED] times since the [REDACTED] denied his request for the Portable Supports Program. Appellant testified he thinks the Portable Supports program would be cheaper. The CMH would be responsible for [REDACTED] of the cost and he would be responsible for the other [REDACTED]. Appellant stated he wants to get the better treatment regardless of whether it is the ACT program or the Portable Supports program so he can stay out of the hospital.

The Appellant bears the burden of proving by a preponderance of the evidence that CMH did not properly deny him an Adult residential placement in accordance with the Code of Federal Regulations (CFR). Appellant has not met his burden in this case. The relevant Medicaid policy provides that the CMH may deny services 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. In this case the Access Center determined that the ACT Dual Diagnosis Program was a more appropriate program suited to meet the medical needs of the Appellant. It is a more intensive treatment program, and is provided in the least restrictive environment for the Appellant than an Adult residential placement in the Portable Supports Program would provide. Accordingly, CMH was correct in denying Appellant's request for Adult Residential Placement.

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 Adult 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]

WDB/db

cc: [REDACTED]

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***** 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.