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. 2014-30183 CMH
Case No.

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 . , Appellant's guardian, appeared and testified on Appellant's behalf. Appellant's witnesses were , Home Manager, ; , Case Manager; , Program Manager; , Clinical Director, ; and , Appellant.

, Assistant Corporation Counsel, (CMH), represented the Department. , CMH Director, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request for continued 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 Medicaid beneficiary, born , receiving services through (CMH). (Exhibit A, Attachment C, p 10; 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. (Testimony)

3. Appellant is diagnosed with schizoaffective disorder. Appellant presents with paranoia and vocalizes suspicions that everyone is out to sabotage him. Appellant vocalizes limited insight to his mental illness or his current

level of functioning and ability to be independent. (Exhibit A, Attachment C, pp 17, 27; Testimony).

4. Appellant currently lives at [redacted]. Appellant is non-compliant at times, refusing to do tasks around the home or his own ADL's and personal care. Appellant refuses to go to program activities and he often stays in bed all day. Appellant is incapable of making his own doctor's appointments or arranging transportation for himself. (Exhibit A, Attachment C, pp 10, 17; Testimony).

5. Appellant does not have any disabilities or impairments that would require assistance with his personal care, but Appellant chooses not to attend to his personal care or dental hygiene. Appellant will wear the same soiled clothes for over a week, will ignore staff prompting and encouragement to shower or change his clothes and will become aggressive towards staff when confronted. (Exhibit A, Attachment, p 18; Testimony).

6. On [redacted], CMH sent a notice to Appellant informing him that continued residential placement would not be authorized because Appellant was refusing to participate in treatment at the CLF home. Appellant was informed that CMH would support placement in a general AFC home where Appellant could be supervised, but would not be forced to participate in treatment. (Exhibit A, Attachment A, p 6)

7. 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:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA
Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA
The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

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
January 1, 2014, pp 12-14

The CMH witness testified that the CLF home where Appellant resides is not housing, but a treatment environment. The CMH witness indicated that Appellant's placement in the CLF group home is an environment that is "intended to treat, ameliorate, diminish or stabilize" his symptoms. The CMH witness testified that because Appellant refuses to actively engage in his treatment, he is not meeting the criteria of medical necessity for the CLS home placement. The CMH witness indicated that Appellant would be better served in a general AFC placement, where there would still be 24 hour staffing to

monitor him, but he would not be in a treatment environment where he refuses to participate in treatment.

The Home Manager where Appellant resides testified that staff help Appellant with medication administration, cooking, transportation to appointments, and prompt him for hygiene.

The Clinical Director at testified that Appellant is quite stable at his current level of treatment and has been doing well. The Clinical Director testified that Appellant does, however, need frequent prompting. The Clinical Director indicated that she understood the 's concern with regard to Appellant not participating in services, but she indicated that his refusal to participate is related to his mental illness. The Clinical Director indicated that Appellant can become very depressed at times and during these times his participation in activities decreases. The Clinical Director opined that Appellant would struggle greatly in an environment where staff did not care for him at the level he receives in his current environment.

Appellant's Case Manager testified that over the past 2 months, Appellant has been more active, has done his laundry, is showering more regularly, attending day programming, following home rules, and putting groceries away. Appellant's Case Manager testified that she has developed new goals for Appellant recently given his increase in activity and participation.

Appellant's Program Manager testified that Appellant has only been working with his new Case Manager since and has been working on goals to transition to a more independent living environment since that time. Appellant's Program Manager indicated that Appellant is interested in a more independent setting and is capable of achieving this goal.

Appellant testified that if he ends up in an AFC home or a boarding room, he likely would not stay there and would run away. Appellant indicated that at an AFC home he would have little supervision, no transportation, no rights, and he would have difficulty taking his medication and eating. Appellant testified that he thinks he can reach his goals of living more independently if he is allowed to remain in the current setting a little longer.

Appellant's guardian testified that Appellant needs to remain in the current residential placement if he is to meet his goals. Appellant's guardian testified that if he is removed from his current setting, he likely will remain homeless.

At the time the Department made its decision, Appellant was refusing to participate in his treatment and take care of his personal hygiene. As such, placement in the CLF home could not be authorized because the placement could not "treat, ameliorate, diminish or stabilize" his symptoms because he was not participating in any treatment. Furthermore, under the medical necessity criteria outlined above, there was a more clinically appropriate, less restrictive and more integrated setting in the community for

Appellant, specifically an AFC home. 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."

Appellant bears the burden of proving by a preponderance of the evidence that continued residential placement is a medical necessity in accordance with the Code of Federal Regulations (CFR) and Medicaid policy. Appellant did not meet the burden to establish that such placement was a medical necessity at the time the CMH made its decision.

As it appears that Appellant is now more fully engaged in his treatment at the CLF home, he and his guardian may wish to request another assessment of his needs based on his current participation. However, based on the information the CMH had at the time it made its decision, Appellant was refusing to participate in treatment and take care of his own personal hygiene. As such, the decision was correct at the time it was made.

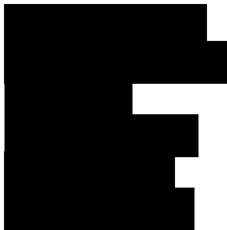
DECISION AND ORDER

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

RJM/

Date Signed:

Date Mailed:

***** 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.