STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 15-002617 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], Case Manager, Specialized Residential Services (SRS) appeared on Appellant's behalf. [redacted], Appellant's sister; [redacted], brother-in-law; [redacted], Manager, [redacted]; [redacted], Nurse, SRS; and [redacted], Supervisor, SRS appeared as witnesses for Appellant. Appellant also appeared, but did not testify.

[redacted], Assistant Corporation Counsel, [redacted] Community Mental Health Authority (CMH), represented the Department. [redacted], CMH [redacted] Manager, appeared as a witness for the Department.

ISSUE

Did the CMH properly terminate Appellant's 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. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted], receiving services through Macomb County Community Mental Health (CMH). (Exhibit A, p 10; Testimony)

2. CMH is under contract with the Department of Health and Human Services (DHHS) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant is diagnosed with simple type schizophrenia chronic state. (Exhibit A, p 31; Testimony).

4. Appellant is prescribed the medication Risperdal. (Exhibit A, p 12)

5. Appellant is a Veteran with an extensive employment history and three years of college experience. Appellant's symptoms include delusional thoughts about marriage and divorce (he was divorced in [redacted]), but he is easily redirected. Appellant has difficulty making positive choices regarding his future but he is doing well in his current setting. (Exhibit A, p 17; Testimony).

6. Appellant has not been admitted to a psychiatric hospital in the past [redacted] plus years. (Exhibit A, p 17; Testimony).

7. Appellant has a supportive family, including his father and sister, whom he sees frequently. Appellant enjoys woodworking and cooking complicated meals. (Exhibit A, pp 17, 35; Testimony)

8. Appellant currently receives adult residential placement through CMH, paid for with a combination of Personal Care Services and Community Living Supports (CLS). Appellant resides in a semi-independent placement (SIP) called [redacted]. The SIP is set up in an apartment complex and each resident, including Appellant, has a roommate. Residents are responsible for purchasing their own food and household supplies. Transportation is provided by the complex. Appellant has taken the SMART bus in the past, but does not use it independently on a regular basis. (Exhibit A, p 17; Testimony).

9. At the time of the request for hearing, services provided through CMH included targeted case management, treatment planning and service review, medication review, and RN services. (Exhibit A, pp 43-44; Testimony)

10. Because Appellant lacks insight into his illness, and does not believe he needs medications long-term, Appellant's medications have to be administered to him on a day to day basis. Staff is working toward transitioning Appellant to a 3 day supply of his medication, whereby Appellant would be given a 3 day supply of his medications and he would be responsible for taking them on his own, but at this time Appellant still needs to have his medications administered daily. (Exhibit A, p 17; Testimony)

11. On [redacted], Appellant's Annual Assessment was completed. The assessment indicates under the title "Discharge planning":

> The consumer will continue to be assessed to transition to the least restrictive level of care. The consumer's upcoming plan of service will have objectives that focus looking at transitioning to outpatient services and independent living facility. The consumer will demonstrate an increase in his

> compliance with medications, ability to manage and pay bills, and less dependence upon staff for transportation. (Exhibit A, p 17; Testimony)

12. On [redacted], Appellant's Persons Centered Plan was completed. At that time, staff noted, "[redacted] is currently at a least restrictive level of care and would need to accomplish all goals and objectives to transition to a lower level of care that would include outpatient and CLS services. (Exhibit A, p 43)

13. On [redacted], CMH sent notice to Appellant informing him that his adult residential placement was being terminated. CMH allowed Appellant 80 days of continued residential placement to make other arrangements for housing and treatment. (Exhibit A, p 6; Testimony)

14. 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)**
>
> 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.

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
October 1, 2014, pp 119, 12-14

CMH's [redacted] Manager testified that the [redacted] reviews requests for services and determines if those services are medically necessary. CMH's [redacted]

[redacted] Manager reviewed Appellant's age, diagnosis, and the services he is currently receiving. CMH's [redacted] Manager testified that Appellant is able to take care of his personal needs, but does need assistance with medications. CMH's [redacted] Manager indicated that Appellant does not drive, but can take the [redacted] bus. CMH's [redacted] Manager reviewed the function of Personal Care Services and Community Living Supports. CMH's [redacted] Manager indicated that if Appellant is not in a residential placement, he will not be able to access CLS services because he has a Medicaid spend-down. CMH's [redacted] Manager testified that the [redacted] has a Residential Placement Team and that the team concluded that residential placement is no longer necessary for Appellant.

Appellant's Case Manager testified that if Appellant is removed from his current placement, he will not receive any services. Appellant's Case Manager indicated that Appellant is not ready to be on his own with no services due to his mental health and his need to have his medications administered to him. Appellant's Case Manager explained that Appellant lacks insight into his illness and does not believe that he needs to take medications on a long-term basis. Appellant's Case Manager indicated that Appellant is still on a day to day medication regiment, whereby staff administers his medications to him every day. Appellant's Case Manager explained that some residents are given medications for 3 days at a time, or longer, and are trusted to take the medication, but Appellant is not ready for that responsibility presently. Appellant's Case Manager testified that Appellant does not meet all of his daily living needs and needs extensive prompting and reminding to take care of himself. Appellant's Case Manager indicated that Appellant has difficulty scheduling appointments and that while he has taken the [redacted] bus in the past, he does not do so on a regular basis independently. Appellant's Case Manager testified that Appellant's family is not always available to assist him because they work and that Appellant needs consistent and frequent support. Appellant's Case Manager indicated that Appellant can go shopping and prepare good, but staff needs to check on him to make sure that he is eating healthy.

Appellant's Nurse testified that Appellant knows what his medications are but he does not understand that he needs to take them. Appellant's Nurse indicated that Appellant often tells staff that he will someday not need to take any medication. Appellant's Nurse explained that Appellant is on a day to day medication regiment, but they are working on increasing this to a 3 day regiment. Appellant's Nurse testified that there is no way Appellant could set up and take his medication on his own at the present time. Appellant's Nurse testified that Appellant would need to be on a consistent weekly medication regiment before he would be ready for independent living. Appellant's Nurse testified that Appellant needs assistance with making healthy living choices. Appellant's Nurse relayed an incident where Appellant thawed meat for cooking by letting it sit out on the counter all day and left a submarine sandwich out on the counter all day so that it would be "warm" when he ate it.

Appellant's sister testified that there were a number of discrepancies in Appellant's latest psychological evaluations. Appellant's sister indicated that contrary to the

evaluations, Appellant's thoughts are not logical and he does have memory problems. Appellant's sister indicated that Appellant simply does not recognize that he has a problem. A copy of the evaluation, with notes regarding the discrepancies, was received after the hearing and accepted as Exhibit 2.

Appellant bears the burden of proving by a preponderance of the evidence that residential placement is a medical necessity in accordance with Medicaid policy and the Code of Federal Regulations (CFR). Here, Appellant has met that burden.

On [redacted], Appellant's Annual Assessment was completed. At that time, staff indicated that Appellant would continue to be assessed to transition to the least restrictive level of care and that his upcoming plan of service would incorporate objectives to help him increase his compliance with medications, his ability to manage and pay bills, and lessen dependence upon staff for transportation. The plan of service was completed two days later, on [redacted], and it was noted, "[redacted] is currently at a least restrictive level of care and would need to accomplish all goals and objectives to transition to a lower level of care that would include outpatient and CLS services." Then, less than 2 weeks later, CMH notified Appellant that his adult residential placement was being terminated. And, while the CMH did allow Appellant 80 days to transition to a more independent setting, it does not appear that Appellant has made much progress with his goals, at least with regard to medication management, since that time.

Therefore, it is concluded that CMH's decision to terminate Appellant from adult residential placement was improper because at the time of the notice, Appellant could not be safely cared for in a less restrictive environment because of his need for daily medication oversight.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly terminated Appellant's adult residential placement.

IT IS THEREFORE ORDERED that:

The CMH decision is **REVERSED**.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

RJM/[redacted]

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.