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. 15-017259 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 telephone hearing was held on [redacted]. Appellant appeared and testified.

[redacted], Assistant Corporation Counsel, represented Respondent, [redacted] County Community Mental Health Authority (CMH or Department). [redacted], Access Manager, appeared as witnesses for the Department.

Respondent's Exhibit A pages 1-41 were admitted as evidence.

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 [redacted] year old Medicaid beneficiary, born [redacted], receiving services through [redacted] County Community Mental Health Authority (CMH). (Respondent's Exhibit A, page 1; Testimony)

2. CMH is under contract with the Department of Health and Human Services (MDHHS) formerly Michigan Department of Community Health (MDCH), to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant is diagnosed with bipolar disorder, NOS and generalized anxiety disorder. (Respondent's Exhibit A, page 1; Testimony).

4. Appellant currently resides in adult residential placement.

5. On [redacted], the Respondent sent Appellant notice that his adult residential placement service would be terminated effective [redacted], because of ongoing non-compliance with treatment. (Respondent's Exhibit A page 5)

6. On [redacted], the Michigan Administrative Hearings System received a request for a hearing from Appellant stating that he still needs the program because he does not have the ability to support himself 100%. He will work on taking his meds on time. (Respondent's Exhibit A page 7)

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 (Department of Health and Human Services or Department) 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.
>
> **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

Appellant testified that he cannot live on his own because he needs help with budgeting. He has no assets or credibility to live on his own.

The Respondent's representative indicated that adult residential placement through CMH is not intended to be a permanent housing solution. Rather, placement is with the intention of training and treatment. Personal care services and community living supports in a CLF or SIP setting are intended to assist the beneficiary in stabilizing his or her psychiatric condition and acquiring the skills necessary to move forward into more independent levels of care.

The Access Center denied Adult Residential Placement or Supported Independent Placement (SIP) for Appellant for the reason that his is not compliant with treatment. Appellant's person centered plan lists several goals that would enable Appellant to work toward living independently. However, case notes indicate that he was rarely in the community living facility (CLF) group home. He was gone most days and several nights and was not compliant with his medications. The Specialized Residential Services Team did not recommend continued CLF placement. In an attempt to continue care for Appellant, the Access Center authorized a three month placement with SIP. However, the authorization required appellant to demonstrate compliance with treatment, working on his goals in his person-centered plan, following the rules and being present in the SIP to interact with the staff, if authorization were to be continued beyond three months. Unfortunately, Appellant chose to follow the same pattern of not participating in treatment that he exhibited in his CLF and his authorization was not renewed. (Respondent's Exhibit A pages 26-41)

The Department also alleged that since Appellant does not engage in the treatment offered in the setting, he is not deriving benefit from the treatment setting. Because he is not deriving any benefit, there is no justification to keep him in that level of care. He can be supported in a general AFC home with appropriate supports such as medication management, case management and outpatient therapy.

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.

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 Adult Residential Placement.

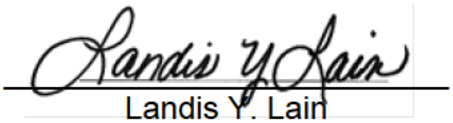
Appellant bears the burden of proving by a preponderance of the evidence that residential placement at InterActions is a medical necessity in accordance with the Code of Federal Regulations (CFR) and Michigan Medicaid policy. Appellant did not meet the burden to establish that such placement is a medical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



Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[redacted]

Date Signed: November 12, 2015

Date Mailed: November 12, 2015

***** 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.