STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-14884CMH
Case No. [redacted]
Load No. [redacted]

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 [redacted]. [redacted] authorized representative, appeared on behalf of the Appellant. [redacted], appeared as s witness for Appellant. [redacted] (Appellant) appeared at the hearing, but did not testify. [redacted], represented the Department's agent, [redacted], appeared and testified as a witness for the Department.

ISSUE

Did the MCCMH properly determine Appellant's eligibility for Community Living Supports (CLS) services?

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] and Medicaid and Medicare beneficiary who was diagnosed with moderate mental retardation. (Exhibit 1)

2. At the time relevant to this matter, Appellant was living with her Stand-By Guardian, and her guardian's family.

3. [redacted] is a Prepaid Inpatient Health Plan (PIHP) under contract with the Michigan Department of Community Health (Department) to provide Medicaid covered services to Medicaid beneficiaries who reside in the [redacted] Health service area.

4. Appellant was not enrolled in the Habilitation and Supports Waiver (HAB Waiver) program at any time relative to this matter.

5. Appellant was approved for 128 hours and 26 minutes of Home Help Services at the time relevant to this matter.

6. A request for 20 hours per day of CLS was requested on Appellant's behalf.

7. According to a [redacted] Annual Assessment report dated [redacted] Appellant did not have any reported medical problems and was not taking any prescribed medications; Appellant did not complete high school; Appellant requires assistance with her activities of daily living (ADLs), which include toileting (Appellant wears diapers), bathing, grooming, brushing her teeth, dressing (Appellant tries to complete the task herself "but will button things the wrong way, put her shoes on the wrong feet, and put her clothes on backward"), combing her hair, meal preparation, money management and budgeting, medication administration and management; Appellant's guardian has safety precautions in place such as alarms on the doors and windows, and Appellant knows what to do in the event of an emergency; Appellant requires training and prompting with structuring her day effectively; Appellant can ambulate without assistance but struggles with a few fine motor delays; Appellant can drink and feed herself independently; and Appellant goes everywhere with her family. (Exhibit 1, p. 19)

8. It was determined that Appellant continues to need CLS services to increase her independence with daily living tasks.

9. [redacted] approved Appellant for 4.2 hours per day (30 hours per week) of CLS for the period of [redacted] through [redacted], which is 2092 units for the authorization period instead of the 10458 that was requested. (Exhibit A)

10. On [redacted], the MCCMH sent an Adequate Action Notice to Appellant's legal guardian, stating the number of CLS units that Appellant was approved for. (Exhibit A)

11. On [redacted], the State Office of Administrative Hearings and Rules, received a hearing request, filed on Appellant's behalf, protesting the number of CLS units that Appellant was approved for.

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*

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…

Section 1915 (c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide Medicaid funded services through the CMH Managed Care Provider Network to persons who meet the service selection criteria for Medicaid funded services.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.* CMH is required to use a person-centered planning process to identify medically necessary services and how those needs would be met. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

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.

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.

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/Substance Abuse section, Version Date: October 1, 2008

The Department's policy with regard to Community Living Supports services is found in the Medicaid Provider Manual, Mental Health and Substance Abuse Service Chapter. Because the Appellant is neither enrolled in the Children's Waiver nor the Habilitations and Supports Waiver, Community Living Services are only available to the Appellant as a B3 service. The Department's policy criterion for authorizing B3 services is as follows:

> **Section 17.2**
>
> The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:
>
> - The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter and the MDCH/PIHP Contract, Section 1.2; and
> - The service(s) having been identified during person-centered planning; and
> - The service(s) being medically necessary as defined in MDCH/PIHP Contract, Attachment P.3.2.1, Medical Necessity Criteria, as amended; and
> - The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
> - Additional criteria indicated in certain B3 service definitions, as applicable.
>
> Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse Services, Section 17.2, October 1, 2008.*

The Department's purpose and coverage description for B3 Community Living Services is provided in Section 17.3. B. This policy provides in pertinent part:

> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> -Coverage includes:
>
> - Assisting, reminding, observing, guiding and/or training in the following activities:
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
> - shopping for food and other necessities of daily living.

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment. (Underline added.).

Staff assistance, support and/or training with activities such as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- socialization and relationship building
- transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and nonmedical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. **CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.**

Medicaid Provider Manual, Mental Health and Substance Abuse Services, Section 17.3.B, October 1, 2008.

The Department's policy with regard to Skill Building Assistance is found in the Medicaid Provider Manual, Mental Health/Substance Abuse Service Chapter. The Department's policy for authorizing this service is as follows:

Section 17.3.K. Skill Building Assistance

Skill-building assistance consists of activities that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community setting. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary' MRS eligibility conditions change.

Medicaid Provider Manual, Mental Health/ Substance Abuse, Section 17.3.K, October 1, 2008

According to a MCCMH Annual Assessment report dated [redacted] Appellant did not have any reported medical problems and was not taking any prescribed medications; Appellant did not complete high school; Appellant requires assistance with her activities of daily living (ADLs), which include toileting (Appellant wears diapers), bathing, grooming, brushing her teeth, dressing (Appellant tries to complete the task herself "but will button things the wrong way, put her shoes on the wrong feet, and put her clothes on backward"), combing her hair, meal preparation, money management and budgeting, medication administration and management; Appellant's guardian has safety precautions in place such as alarms on the doors and windows, and Appellant knows what to do in the event of an emergency; Appellant requires training and prompting with structuring her day effectively; Appellant can ambulate without assistance but struggles with a few fine motor delays; Appellant can drink and feed herself independently; and Appellant goes everywhere with her family.

In this case, the [redacted] representative and witness provided sufficient evidence to establish that [redacted] acted properly and authorized CMH CLS services in accordance with the state Medicaid policy and Appellant's Personal Care Plan. Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. See 42 CFR 440.230.

Appellant has been receiving Home Help Services through the Department of Human Services (DHS) which pays for physical assistance with her activities of daily living and instrumental activities of daily living. Appellant was approved for 128 hours and 26 minutes of Home Help Services per month at the time relevant to this matter, in addition to the 30 hours per week of CLS hours through MCCMH. It was determined that Appellant continues to need CLS services to increase her independence with daily living tasks. In this case, Appellant's guardian/representative did not meet her burden of proving by a preponderance of evidence that the CLS services that were authorized by [redacted] were insufficient to achieve the goal listed in Appellant's Personal Care Plan. Further, she failed to establish that it is medically necessary for Appellant to receive 20 hours of CLS on a daily basis. Therefore, the CLS eligibility determination must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly determined Appellant's eligibility for community living supports.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/18/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.