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. 2009-11454 CMH
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], the Appellant's legal guardian and Great Aunt represented the minor Appellant. [redacted] (CMH), represented the Department's contracted PIHP. [redacted] also appeared and testified. [redacted] appeared as an advocate witness for the Appellant. [redacted] for the Appellant was present as a witness on his behalf.

ISSUE

Did the Department properly deny Community Livings Supports to the Appellant?

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 [redacted] year-old Medicaid beneficiary. He resides with his legal guardian/Great Aunt and Uncle.

2. The Appellant has been receiving services from a CMH contractor for his medical conditions, which include Autism and ADHD.

3. The Appellant's medical condition results in a medical need for constant monitoring and supervision of the Appellant beyond that which is necessary for a typical [redacted] year old. He exhibits aggression, frequent tantrums which include aggressive

behaviors including striking others and require intervention of at least one adult on a daily basis. He is at risk for elopement in the community and at home.

4. The Appellant's medical condition results in not having safety awareness or age appropriate compliance with adult instruction relative to safety concerns. The Appellant will poke himself with or attempt to swallow objects, does not heed instructions to stay away from the stove or oven. His behaviors are daily and constant, resulting in the disruption of the adults' ability to provide for their own self care. Time away from the Appellant for bathroom use, showering or housekeeping tasks is not possible without another adult monitoring his behavior at all times.

5. The [redacted] are contractors who provide services for eligible participants of the [redacted]

6. Most recently Appellant has been receiving CMH services through its [redacted] contractor.

7. [redacted], on behalf of the Department, has authorized services to be provided in the form of occupational and speech therapy as well as development and implementation of a behavior plan.

8. The behavior plan authorized by the Department is expected to be implemented with a visiting professional at the home approximately 1-2 hours per week.

9. The Appellant's guardian seeks 30 hours per week of Community Livings Supports to assist in implementing the behavior plan with the Appellant.

10. The Department has determined it is not medically necessary to authorize Community Living Supports (CLS) hours for this purpose and has instead increased respite hours from 336 per year to 672 hours per year.

11. The Department has reduced Occupational and Speech therapy provided outside of the school setting from 2 sessions per week each to 1 hour per week each, which could be broken down into multiple sessions, totaling 1 hour per week of each therapy.

12. The Appellant is enrolled in school and receives both Speech and Occupational therapies at school.

13. The Appellant, through his guardian, disagrees with the reduction in the OT and Speech therapy authorizations, as well as denial of the CLS request.

14. No other aspect of the authorization for services in the IPOS is in dispute.

15. The Appellant requested a formal, administrative hearing on [redacted]

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) Medicaid Managed Specialty Services waiver. Macomb County CMH, a Prepaid Inpatient Health Plan (PIHP), contracts with the

Michigan Department of Community Health to provide 1915(b) specialty mental health services. The PIHP's contract with the Department requires that all services paid for with Medicaid funds must be medically necessary. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **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.

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; Version Date: April 1, 2006; Pages 11 through 13

The Appellant is enrolled in the Habilitation and Supports Waiver (HSW). Accordingly, the definition of CLS provided under this section of the Medicaid Provider Manual is applicable to a determination to be made of whether the amount, scope and duration of CLS awarded is appropriate, given the evidence presented.

This section of the provider manual provides, in pertinent part:

15.1 WAIVER SUPPORTS AND SERVICES

Chore Services Services to maintain the home in a clean, sanitary, and safe environment, include:

- Heavy household chores such as washing walls, floors and exterior windows;
- Tacking down loose rugs and tiles;
- Moving heavy furniture in order to provide safe mobility within the home; and
- Removing snow to provide safe access to, and egress from, the home.

These services will only be provided in cases where neither the beneficiary, nor anyone else in the household, is capable of performing or financially providing for them and where no other relative, caregiver, support/service provider, landlord, community/ volunteer agency, or third party payer is capable of, or responsible for, their provision.

In the case of rental property, the responsibility of the landlord, pursuant to the rental or lease agreement, must be examined prior to authorization of the service. This service may not be provided to beneficiaries who live in licensed settings because the activities are the responsibility of the home's licensee.

17.3.B. COMMUNITY LIVING SUPPORTS

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 appears to be needed, the beneficiary 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. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- 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 non-medical 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 coverage Personal Care in Specialized Residential Settings. 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.
.

Michigan Department of Community Health
Medicaid Provider Manual
Mental Health/Substance Abuse; Version Date: April 1, 2009
Page 96

The Department's agent asserts that provision of CLS hours is not medically necessary as a [redacted] year old is not going to be independent or self sufficient in the community. It was asserted the goals of CLS are not met by providing in home supports such as those needed by Appellant. Additionally, it is not an appropriate use of CLS hours. Instead, the Department asserts provision of extra respite care can provide relief to the Appellant's care takers due to the extra energy required to effectively supervise and protect the Appellant.

The Appellant, through his guardian and witnesses, asserts it is appropriate to use the CLS to achieve progress in socialization, relationship building, and preserving the health and safety of the Appellant. This could be done both in the home and out of the home. Additionally, use of CLS hours could aid in the implementation of the behavior plan. The behavior plan itself meets a goal of CLS, that of socialization and would aid the Appellant in conforming his behavior such

that he could participate in the Community more often and with more success.

The uncontested evidence of record clearly establishes the Appellant requires a high level of intervention for his safety alone. Additionally, he requires services to support attempts at socialization and development of more appropriate behaviors such that he is able to participate in community settings and activities. He has such a high level of need his caretakers are unable to find time for their own ADL's and IADL's due to his need for constant, intensive supervision and redirection. He will strike out and engage in lengthy tantrum behavior to such a degree that more than one adult must intervene. His current behavior is such that he is unable to participate in community setting to a large extent due to inability to follow direction, safety concerns, tantrums and elopement concerns. The appropriate uses of CLS hours as stated in the Medicaid Provider Manual cited above support the authorization request made by the Appellant. Use of CLS hours is not prohibited for consumers aged [redacted] years old. While the assertion that the Appellant is not going to achieve self sufficiency and independence in the community at this time, at his age was considered, authorization for such a service is appropriate to meet the goals of socialization, relationship building, and even safety. This ALJ finds the Appellant did meet his burden of establishing authorization of CLS is medically necessary to meet the goals as stated. Based upon the materially uncontested testimony relative to the Appellant's behavior, the evidence supports a finding that provision of 30 hours of CLS per week is appropriate.

The Department's determination of the appropriate amount of O.T. and speech therapy authorized for the Appellant is upheld. The uncontested evidence that the therapies authorized could be broken down into smaller segments evidences an authorization consistent with the severely restricted attention span of the Appellant. The testimony from the Appellant's guardian was directed to the number of times the therapies were provided each week rather than the length of each session. She did not provide material evidence the authorization is inadequate to meet the medical needs of her ward.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant's request for 30 hours of CLS per week is medically necessary.

The Department's authorization for speech and occupation therapy is appropriate to meet the medical needs of the Appellant.

IT IS THEREFORE ORDERED that:

The CMH's decision is REVERSED in part and UPHELD in part.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _____4/22/2009___

***** NOTICE *****

SOAHR 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 SOAHR 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.