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. 2010-20768 CMH
[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] appeared on behalf of the Appellant. Her witnesses included; the Appellant, [redacted] (personal assistants) and [redacted], the Appellant's father. [redacted], manager, represented the Department. Her witness was [redacted], supports coordinator. Also in attendance was [redacted], services director [redacted].

ISSUE

Did the Department properly reduce CLS services for the Appellant?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. The Appellant is a Medicaid beneficiary and is enrolled in the [redacted]). His diagnoses include Barrett esophagus, history of Major Depression, Psychotic, Cerebral Palsy, Extremity Contractures, and Swallowing Dysfunction. He also suffers a significant speech impediment. (Department Exhibit A, - throughout and Appellant's Exhibit #4 – throughout)

2. Currently, the Appellant receives 14 hours [daily] of Community Living Supports (CLS) and Monitoring. He is alone and without any assistance between 3 and 4 hours on average per day.

3. On [redacted] the Department met with the Appellant and his representative to revise his person-centered plan. (Department's Exhibit A, pp. 2 and 3)

4. At the PCP the Appellant identified his non-DHS needs for [redacted] including enhanced supports for eating, showering, toileting grooming/dressing, night time turning, communication support, community inclusion, home maintenance, unforeseen illness and staff meetings – averaging 12 hours of support per day. (Department's Exhibit A, pp. 3, 4.)

5. The Department proposed 12 hours of supports per day based on clinical observation and an absence of supporting documentation. (Department's Exhibit A, p. 5)

6. The Appellant's DHS/HHS support remains extant at 4.8 hours per day. (Department's Exhibit A, p. 2 and Appellant's Exhibit #2, p. 3)

7. The Appellant was notified of the reduction in CLS on [redacted] – with an effective date of [redacted]. (Department's Exhibit A, p. 2)

8. The instant appeal was received by the State Office of Administrative Hearings and Rules (SOAHR) 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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. Northeastern Michigan Community Mental Health (NEMCMH) contracts with the Michigan Department of Community Health to provide services under the HSW.

The Appellant may receive Medicaid funded B3 services as long as those services do not replace or duplicate State Medicaid Plan Specialty Supports and Services or HSW services and he meets the criteria for B3 supports and services.

[ ] 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.
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> Medicaid Provider Manual, (MPM) Mental Health [ ], §17.3.B, pages 100-101, April 1, 2010

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Neither [redacted] nor the Appellant disputes the Appellant's continuing eligibility for [redacted] services including CLS. They further agree that the only issue on appeal was the denial of the Appellant's requested amount of CLS.

From a review of the testimony and the evidence, it appears that the Appellant is also concerned about his long standing relationship with the Department which, over the years, has had some rough edges. In his written testimony the Appellant warned the ALJ that I would witness bad behavior, accusations and pointless historical retorts at hearing. *See* Appellant's Exhibit #2, p. 1.[1]

In fact, the Appellant identified and agreed with the Department's assertion that he had not delivered a long promised functional assessment. This assessment would be critical evidence for the Appellant on several levels – but of most importance - it is the key to maintaining or increasing his CLS today or in the future.

[1] Actually, nothing of the sort occurred. The hearing was orderly and parties and their witnesses were polite and respectful of each other.

As of the date of hearing the evidence and the testimony established that the Appellant needs CLS. His aides testified about their level of activity (generally) and the hours that they work when questioned by the ALJ. Their actions were in line with the department's assessment.

One underlying issue is the Appellant's concern with being alone at night in the event of an emergency. It was stipulated at hearing and observed by the ALJ that the Appellant is difficult to understand – thus, a 9-1-1 call during an emergency (while alone) might well lack effectiveness or result in increased response time.

The Department witnesses testified however, that further technological advances now permit a sophisticated monitoring system that would initiate nearby emergency services without action by the Appellant. The Appellant is suspicious of this technology and is resistant to reducing his dependency on the (human) supports system,

The Appellant argues he needs overnight supervision in the event of an emergency or technological failure. However, the record lacks relevant, current medical or evidence indicating the Appellant needs 24-hour supervision and care.[2] The evidence also provides no indication the Appellant needs supervision during sleep hours on a regular and consistent basis. *See* Appellant's Exhibit #4 – throughout.

The Appellant argues that he needs 14-hours of services owing to his propensity for choking and his nightly need for turning in bed. He added today that his landlord, by way of lease agreement, now requires that he prove an ability to get in and out of the facility.[3]

- The Appellant is an intelligent person and he is fully engaged in the Self Determination program. He acknowledges that his pledged functional assessment has been delayed though no fault of the Department. (Appellant's Exhibit #2)

- His own aides tallied their hours on recent reassessment and came up with fewer necessary hours than the Department authorized for [redacted]. (Department's Exhibit A, p. 5)

Absent documentary evidence providing the Department with proof of medical necessity for additional hours the Appellant has failed to preponderate his burden of proof. Accordingly, the Department's assignment of CLS was both reasonable and within policy which requires proof of medical necessity.

In determining its authorization for CLS, [redacted] must apply the Department's medical necessity criteria. The Medicaid Provider Manual policy for medical necessity is as follows:

[2] Although there is a note from [redacted] to call [redacted]" on [redacted], about providing documentation of service time and needs. (Appellant's Exhibit #4, p. 27)
[3] Another issue not heretofore noticed to the Department until the date of hearing.

[ ] MEDICAL NECESSITY CRITERIA

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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.

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Using criteria for medical necessity, a PHIP may:

- 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.
>
> MPM, Mental Health [ ],
> Medical Necessity, §§2.5 A, D, pages 12 - 14.

It appears from a review of the evidence that chief among the Appellant's concern is fear of the unknown, which is more than understandable. However, the onset of indecision can be significant as well. Either way, the medical evidence presented by the Appellant does not support a conclusion that direct human nighttime supervision is medically necessary, or that the Appellant requires an additional 2 hours of CLS.[4]

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the number of CLS hours offered and proposed [12-hours] by the Department in the [redacted], Person Centered Planning agreement is appropriate to the Appellant's current need.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/5/2010

[4] As for the electric-lift issue raised obliquely in the pleadings the ALJ observes that Medicare pays first and Medicaid pays last – if at all. And assistive technology is referenced in Chapter 17 of the Medicaid Provider Manual. Beyond that since no service has been denied, reduced or suspended, so there is nothing for the ALJ to decide.

***** 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.