STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-36962 CMH
[redacted], Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] was represented by [redacted]. [redacted] was present on his behalf.

[redacted], represented the PIHP on behalf of the Department of Community Health (CMH). [redacted] was present. Additional witnesses present included: [redacted] and Appellant.

ISSUE

Did CMH properly deny the Appellant's request for an increase in Community Living Services to 24 hours per day?

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] Medicaid beneficiary who is developmentally disabled.

2. The Appellant is diagnosed with Autism, mental retardation, gastroenteristis, chronic self injurious behavior and PICA. He is visually impaired and non-verbal.

3. The Appellant is dependant in his activities of daily living and is not ambulatory at the current time, although he has been ambulatory in the past.

4. The Appellant's self injurious behavior (SIB) is severe and is most notable for hand biting and shoulder rubbing. His SIB is described as severe and can last for weeks at a time. Skin wounds result from his SIB.

5. The Appellant has resided in an institutional setting in the past. He is currently residing in the family home in [redacted].

6. The Appellant is served by the Home Help program administered by the Department Human Services, as well as Community Mental Health services.

7. The Appellant's Home Help Services were originally approved at 78 hours per month, however, were significantly reduced by the Department of Human Services. His mother is his HHS provider.

8. The amount of services approved through the Department of Human Services is currently under appeal. No final disposition has been made as of this writing.

9. The Appellant is eligible to attend school full time, however, is not attending school as of the hearing date.

10. The Appellant is functionally dependent on others for his activities of daily living. He requires full hands on assistance with those tasks and is not toilet trained.

11. The Appellant has insomnia.

12. The Appellant requires 24 hours-a-day supervision in order to be safe.

13. The Appellant's guardians/parents requested an increase in CLS hours to 24 hours per day.

14. The CMH denied the Appellant's request for an increase in CLS hours to 24 per day; however, 14 hours per day was approved in response to the request for an increase.

15. The Appellant's guardians/parents requested a formal, administrative hearing [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. [redacted] (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. 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.

The Medicaid Provider Manual specifies what supports and services are available for persons such as the Appellant. It states 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.
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> **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.

Community Inclusion and Participation
The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).

Independence
"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity
Engaged in activities that result in or lead to maintenance of or increased self sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services,

individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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 service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; 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 and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

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.** (emphasis added)

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.
>
> Medicaid Provider Manual
> Mental Health/Substance Abuse
> Version Date: January 1, 2010, Pages 97-101
> Michigan Department of Community Health

In this case, it is undisputed that CLS services are medically necessary for the Appellant. He is authorized to receive 14 hours per day CLS. His mother and representative assert 24 hours per day is necessary to address his needs. Among the uncontested, material evidence is evidence that the Appellant is on a special diet, he is non-ambulatory at this time, he has insomnia, thus is not sleeping through the night. The Appellant not only engages in severe SIB, he also is diagnosed with PICA, thus if left unsupervised, will place objects into his mouth, placing himself at risk. The Appellant's SIB is so severe he leaves skin wounds on his body.

The Appellant is not attending school at this time and his teacher provided testimony that there was nobody available to address his severe SIB at school. She testified that he used to participate in some self feeding activity, with guidance. He followed directions and was ambulatory prior to the fall of [redacted]. In [redacted] he began voicing what is believed to be distress, loudly. He began SIB and the school nurse was called, as well as his mother. His hands were wrapped to prevent injury. He has not been in attendance at school much since [redacted].

The Appellant's mother has investigated residential placement for the Appellant but has not found a placement that appears able to meet his needs. [redacted], a nurse, testified the Appellant's activities of daily living include keeping him safe from self injury. A visiting nurse could attend to the Appellant's wound care needs and change dressings, however, a visiting nurse would not be assigned a long shift for the purpose of preventing or responding to SIB. She further testified SIB is part of Autistic behavior.

Over the objections of counsel for the Department, testimony was presented regarding past residential placements the Appellant has experienced. This ALJ allowed the testimony despite the objection of counsel and finds it is relevant, given the assertion that a residential placement outside of the family home is what is best able to meet the Appellant's needs. Testimony from the Appellant's mother regarding the Appellant's experience with placement in a group home or other institutional setting was that he had contracted MRSA, had to be hospitalized and there was a lot of difficulty in successfully treating it. Additionally, he contracted a broken foot that was not attended to or discovered timely. She testified that although she would like to be able to return him to a group home setting for the health and well being of the Appellant's siblings and in recognition of her own limitations, she was not able to do so at this time because he was not healthy in that setting and she was watching him deteriorate.

[redacted], testified she has seen a significant decline in the Appellant's functional status recently and that he is engaged in SIB daily at this time.

The CMH asserts, through testimony presented by witness [redacted], that the Appellant's needs are medical, thus cannot be fully addressed with CLS authorization. Testimony was taken asserting that pain is a trigger for the Appellant's SIB, thus rendering it a medical issue. It was asserted CLS is not appropriate to address the medical cause of the behavior. Furthermore, CMH asserts that 14 hours per day of CLS, in conjunction with the 78 hours per month of HHS is sufficient to address the care needs of the Appellant and if not, a more restrictive setting should be considered. It is asserted the Appellant's care needs can best be met in a more restrictive setting. It was further asserted that a visiting nurse could partially address the needs exhibited by the Appellant. The witness asserted she determined the Appellant's needs are medically based rather than psychologically based by reading records that had been provided her.

The CMH further asserted that the CLS authorization as written into Medicaid Policy for the Children's Waiver participants may be a useful guide in determining how much CLS to authorize and that even a client who requires a high level of care would not be authorized to receive 24 hours of care. While it is true that the most high needs child may not be authorized for 24 hours per day of CLS, the Appellant in this case is not a child. The Policy for authorizing services does explicitly set forth the expectation that the parents of a minor child participant of those services still has an obligation to provide the same amount of care they would to their child if s/he were not in need of the services. However, the Appellant's parents are providing an extraordinarily high level of natural supports, despite not having a legal obligation to do so. The Appellant is an adult, who is residing in the family home. His care needs are being addressed by his family to the extent possible, however, an extraordinary level of care is required by this Appellant. While it is true the Appellant's HHS could be provided by someone other than his mother, at least theoretically, there was still uncontested, credible testimony the Appellant's mother is providing a lot of the Appellants direct care out of necessity.

It is undisputed the Appellant has extraordinarily high and constant care needs. He engages in at least 2 high risk behaviors, SIB and PICA. He is also not sleeping such that a regular respite is provided to his caretakers. He is non ambulatory at this time. He is visually impaired and non-verbal. He is not able to participate with his own ADL's at this time. His recent residential placements outside of his family home have not resulted in acceptable outcomes. While this ALJ considered the assertion from the CMH that the Appellant's needs are best met in a residential placement that is more restrictive than his family home, that is not the choice of the Appellant's legal guardian at this time. As the Appellant's legal guardians, policy not only allows for placement in the least restrictive setting possible but supports and encourages it. Additionally, there was no evidence supporting the claim that a more restrictive setting such as a group home is actually beneficial for the Appellant and has a positive outcome.

The evidence of record establishes the Appellant's extraordinarily high care needs are not met by the current authorization of 14 hours per day of CLS, even in conjunction with the HHS authorization. While 14 hours would normally be sufficient to address even a high needs

client, especially in conjunction with HHS hours, in this case, at this time, it is not. The Appellant's insomnia makes it difficult for this ALJ to find the Appellant is going to sleep for 8 hours per day. He is not in school. Although the school is **required** to provide him an educational program that meets his needs; the fact remains, at this time, he is not attending school. Medicaid policy requires the Department be responsive to the actual, specific care needs of the individuals it serves. Medicaid Policy further specifies that CLS can be used to preserve the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting. Medicaid policy clearly supports authorizing CLS to address the Appellant's safety needs. This requires an authorization of CLS that does address the safety needs of the Appellant, in the least restrictive placement possible. Given that there is no evidence a more restrictive setting is even beneficial for the Appellant at this time, this ALJ cannot find the family home placement for the Appellant is inappropriate. Nor can it be found that the current CLS authorization is adequate to meet the safety needs of the Appellant.

The assertion from CMH witness that the Appellant's SIB is a result of pain associated with his medical conditions rather than his psychological condition of Autism was considered by this ALJ. Even if it were established with uncontested evidence that medically caused pain is a trigger for SIB, the response to the trigger is the result of Autism. The assertion that the request for increased CLS is inappropriate because it is being requested to address a medical problem is an inaccurate analysis of the issue. The Appellant's pain is not causing his self injurious behavior, rather the Appellant's impaired or inappropriate response to pain may result in increased SIB. The impaired/inappropriate pain response is caused by his Autism.

The CMH did not present evidence the goals of the (CLS) service are reasonably met with the current authorization. The Appellant is not safe without constant supervision. Policy states CLS can be authorized for the purpose of assuring safety needs are addressed, thus, it is appropriate to authorize additional CLS hours in this instance. It is difficult to state with certainty, exactly how much sleep the Appellant is engaged in on a daily basis. Furthermore, it is still unknown how much HHS will be ultimately approved for the Appellant. The CLS authorization can and should be adjusted to reflect the circumstances as they change. Thus, when the Appellant returns to school, has an increase in HHS or other circumstances change, it may be appropriate to adjust the CLS authorization. Given the current circumstances, this ALJ finds that at least 18 hours per day of CLS is medically necessary and appropriate to address the Appellant's needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the authorization of 18 hours per day of Community Living Supports are sufficient in amount, scope and duration to reasonably achieve the goals as stated in the person centered plan.

IT IS THEREFORE ORDERED that:

The CMH's decision is REVERSED.

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

cc: [redacted]

Date Mailed 8/5/2010

***** 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.