STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2010-47868 CMH
Case No. [redacted]

Appellant
_____/

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], and continued to [redacted]. [redacted], attorney, represented the Appellant. Her witness was the Appellant's mother/guardian, [redacted]. The Appellant was present for hearing, but did not testify. [redacted], R.N. Director of Clinical Services represented the Department on [redacted], [redacted], Fair Hearings Officer, represented the Department on [redacted]. The Department's witnesses included [redacted], [redacted]; [redacted], Supports Coordinator; [redacted], LPC, CMH; [redacted], Counselor, [redacted]; [redacted], [redacted]; and [redacted], Therapist, [redacted]. Also present but not participating were [redacted], attendant to guardian and [redacted], aide to the Appellant. [redacted], Behavioral Consultant was present but did not testify. Attorney [redacted] was present.

PRELIMINARY MATTER

At hearing, the Appellant's Exhibit #2 was admitted - then later objected to as a post petition document. The document was relevant to the actions taken by the Department at the time of the negative action. The Department's objection was overruled.

ISSUE

Did the Department properly reduce the Appellant's Community Living Supports (CLS)?

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, disabled, Medicaid beneficiary. (Appellant's Ex. 1)

2. The Appellant is identified as an adult male with severe/profound mental

retardation, CP, osteoporosis, and seizure disorder. (Department's Exhibit A, p. 5 and Appellant's Exhibit 4)

3. The Appellant "requires help with all ADLs' [ ] can become physically aggressive when agitated… and acting out." (Appellant's Exhibit 4, pp. 2, 46)

4. In the person centered plan [dated [redacted]], clinicians [redacted], [redacted] and [redacted] conclude that "Based on FAT, it is recommended that [redacted] receive 4 hours of CLS staffing daily, 7 days per, [sic] week to continue to improve behaviors, well as provide community integration opportunities and improve socialization skills…. 1:1 staffing is excessive for behavioral purposes since the severity of the behaviors is considered to be mild." (Department's Exhibit D, p. 3)

5. The Appellant receives service from the [redacted] ([redacted]) via its contractor, [redacted]). He is enrolled with [redacted] as a MCPN. (Department's Exhibit A, p. i)

6. The Appellant received notice advising of his pending decrease in CLS on [redacted]; "We are ending CLS staffing in the day program. [sic] service because CLS protocol has been changed. This will be effective on the following date: [redacted]."[1] (Department's Exhibit B, p. 1)

7. The Appellant's CLS was reduced based on the Functional Assessment Tool (FAT) wherein it was determined that the Appellant scored "zero" on recommendation for 1:1 staffing. The FAT reviewers assessed Appellant's behavior as mild, while the guardian assessed them as medium. The FAT assessment was conducted on [redacted]. (Department's Exhibit C, pp. 3 and 12)

8. The Appellant's PCP dated [redacted], recommended enhanced staffing at 12-hours a day, 5-days a week; 4 hours on Saturday and Sunday; up from 10-hours a day of enhanced staffing established in [redacted]. (Appellant's Exhibit 4, pp. 3 and 36-50 and *See* Testimony of [redacted])

9. The FAT tool presented for evidence states "that specific information in regard to the frequency of the exhibition of behavioral difficulties is not currently available…. Behavioral difficulties as described appear to be mild in severity." The Appellant's guardian countered in written rebuttal on the FAT that the existing staffing level prohibited the acceleration of self-injurious behavior or serious injury to others. (Department's Exhibit C, p. 4 and *See* Testimony of [redacted])

10. The Department has determined by utilizing the FAT assessment tool that the

[1] A copy of the advance notice was received by the Michigan Administrative Hearing System – at hearing – on [redacted].

Appellant's actual need for 1:1 staffing is not necessary because his behaviors are mild [scoring zero] and can be replaced with "chore services." (Department's Exhibit A, p. ii)[2]

11. The Department currently provides the Appellant with CLS, skill building and respite services. (Department's Exhibit A, p. 7)

12. The Appellant requested an administrative hearing before the Michigan Administrative Hearing System for the Department of Community Health 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

[2] And yet, following the instructions found on FAT (calculation page Department's Exhibit C at page 12) the Department determined the Appellant to be "mild" as opposed to "medium" (a one point variance based on information not currently available). Had he been ranked medium he would have scored 8 in Box D, after tallying areas 1-3. The corresponding recommendation of CLS [which were not provided] referred the reader off-chart to Adult Family Home CLS Authorization Guidelines for hours corresponding to certain levels reflected therein.

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 waiver. [redacted] (CMH) contracts with the Michigan Department of Community Health to provide mental health services pursuant to its contract with the Department. [redacted] functions as one of its subcontractors.

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. *See* 42 CFR 440.230.

.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[3] it states, in relevant part:

> **CRITERIA FOR AUTHORIZING**
>
> 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

[3] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12-14, April 1, 2011.

- 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) that 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. (Emphasis supplied)

MPM, Mental Health [ ] §17.2 Criteria for Authorizing B3 Supports and Services, p. 104, April 1, 2011.

Furthermore, the Medicaid Provider Manual (MPM) directs the CMH and service users with the following criteria regarding CLS:

Community Living Supports (CLS)

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 DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from the 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. (Emphasis supplied)

MPM, *Supra* pp. 106-107

****

The Department witnesses testified that the Appellant's grant of CLS on enhanced staffing 1:1 was reduced following FAT assessment wherein he was determined to be "mild" as opposed to "medium at Level 2." Hours were then assigned as "zero" based on FAT scoring at box B on page 12 of the tool.

[redacted], Supports Coordinator, testified that she had not observed the Appellant's behaviors in the day program. She was unable to find an alternate program to [redacted] - usually owing to a transportation issue. She was uncertain if the Appellant's services were presently coordinated.[4]

Witness [redacted] testified that the Appellant's behaviors were not known – but they assessed him as mild anyway because the tool is meant to be utilized to establish ranges – "not everything fits into a hole."

On cross examination the witness acknowledged that the FAT tool was not a measuring device based in law. He acknowledged that services were further based on medical necessity to achieve the goals of the individual as captured in his PCP in the least restrictive means available. He added that the FAT tool worked as a guideline that also determined the amount of help a family might provide.

Although he could not say how many hours the guardian should provide - he acknowledged that those hours would be valuable to the Appellant.

The Appellant's mother/guardian testified that the Appellant cannot be left alone and that he still engages in self abusive behavior including biting his hands, hitting and slapping his head. She said he was not independent in toileting or any other ADL. She said her son was a [redacted]-year old man who won't get any better. To date she provides assistance to the Appellant for all of his ADLs and added that he needs the regimentation that enhanced staffing provides. She said there was very little overlap of services between the CMH and DHS.

On cross examination the witness said that his cognition was not mild – but moderate.

On review the Department's case fails on several levels, first with regard to the FAT tool found at Department's Exhibit C, pages 1-18. The scoring found in this document did not line up with the testimony of any witness. How they could assess behavior and assign a score when they acknowledge that such information was not available is troublesome – particularly when considering the thin line of assessed need debated between the parties at hearing. *See* Exhibit C at page 4.

> ● Further aggravating the decision reached on FAT assessment is its apparent use as the defacto CLS setting protocol – when the testimony of Department's witness [redacted] – clearly indicated that the tool is meant to establish "a range."
>
> ● I found the Department's Exhibit C – [the FAT tool] to be incomplete and untrustworthy in light of the contradictory testimony of the Department's witness [redacted] who had little observed or recalled insight into the needs, behavioral issues and abilities of the Appellant. The testimony of his mother and guardian [redacted] was clearly superior in describing the needs and actual abilities of the Appellant – her written rebuttal on FAT assessment should have carried more weight on [redacted].

[4] Her limited observations of the Appellant's abilities on ADL were fully refuted by the testimony of [redacted]. *See* Transcript at pp. 66 – 135

● Next, the Department witness [redacted] testified that she did not know if services were coordinated. Thus, the Department's decision to rely solely on the FAT could have had devastating consequences for the Appellant but for the actual underlying services. This lack of fundamental knowledge permeated the Department's case and eroded its credibility at hearing. *See* Transcript – throughout.

● Finally, although Appellant's counsel acknowledged receipt of notice there was no enumeration of CLS hours reduced, proposed for elimination or whether they were enhanced staffing hours or not. The "protocol" change was never identified.

Under the MPM [§17.3.B] the Appellant is clearly at a maintenance stage in terms of necessary services. Neither his cognition nor his natural supports[5] are likely to improve or increase in the near term.

In order to maintain his independence and participation in the community at this stage in his life the Appellant's identified needs and goals as found in his IPOS and PCP were satisfied under the standard with 1:1 enhanced staffing at Adult Well Being. This was the appropriate scope, duration and intensity of service reasonably necessary to achieve his goals - which was supported by the evidence and the testimony.

The conclusion relied upon by the Department on FAT assessment represented, at best, a subjective estimate coupled with an erroneous conclusion not supported by either the evidence or the testimony.[6] The testimony does not support the idea that the FAT was being properly utilized as an arbiter of fine distinctions in the elimination of once medically necessary service hours. The testimony did support the idea that the FAT is an instrument best utilized for establishing very general ranges of service.

Also troublesome is the knowledge that the Appellant's services were scheduled for termination by Department notice dated [redacted], to be effective [redacted], "because the protocol changed." A FAT assessment was then conducted after the fact – and utilized at hearing as the justification for the earlier elimination of the Appellant's enhanced staffing.

The Appellant has a person centered plan and is meeting his stated goals with the exisiting 1:1 enhanced staffing, supports and respite. These services are sufficient in scope, duration and intensity to establish and support the achievement of the Appellant's goals and person centered planning. Today, the proposed elimination of 1:1 enhanced staffing was not supported in this record. The Appellant has preponderated his burden of proof.

The Department's decision to eliminate 1:1 enhanced staffing was neither supported in the record as a duplicated service nor was it based on any credible assessment of reduced medical necessity.

[5] His mother/guardian is a senior caregiver with significant health issues. See Testimony of [redacted].
[6] Given the credible testimony and written comments of [redacted] on FAT assessment.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly reduced the Appellant's CLS.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Dale Malewska
Administrative Law Judge
For Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/14/2012

***** 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.