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]

Appellant
_____/

Docket No. 2011-12275 CMH
Case 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 begun [redacted], and continued on successive dates until completed [redacted]. The record was held open for 30 days to allow closing statements to be submitted in writing and closed [redacted].

The Appellant was represented by counsel, [redacted]. The Appellant and his mother were both present for hearing.

The Community Mental Health Authority for [redacted] was represented by attorney [redacted]. Witnesses for CMH included [redacted] and [redacted].

ISSUE

Did the CMH properly deny the Appellant's request for increased community living supports hours?

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 Medicaid beneficiary receiving services through [redacted] Community Mental Health (CMH).

2. The Appellant qualifies for services provided through the CMH as a person with developmental disability.

3. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

4. The Appellant is a [redacted] year-old male. The Appellant's medical status results in him being qualified for services as a developmentally disabled person.

5. The Appellant has a history of severe seizure activity that can require administration of medicine known as Diastat. The CMH, the Appellant and his mother stipulated at the time of hearing that he requires observation 24 hours per day at this time to ensure his safety, due to the history of severe seizures and potential need for administration of the medication to stop them.

6. The Appellant has additional medical issues resulting in a need for Home Help Services.

7. The Appellant has 47.5 hours of Community Living Supports authorized to be provided by paid staff every week.

8. The Appellant is enrolled and eligible for continued full time public education.

9. The Appellant does not desire to live outside of his family home with his mother.

10. The Appellant has a history of frequent absence from school and attendance less than a full day.

11. The Appellant has had brain surgery. This was followed by complications that resulted in needing more surgery.

12. The Appellant has not had a grand mal seizure, as of hearing dates, since his most recent brain surgery, nearly 2 years ago.

13. The Appellant has not had a medical need for Diastat administration in nearly 2 years, since [redacted].

14. The Appellant's mother seeks additional Community Living Supports authorization from Community Mental Health.

15. Following the Denial Notice sent by the CMH, the Michigan Administrative Hearing System received Appellant's request for 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.
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> *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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate amount, scope, and duration to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The Code of Federal Regulations, the state Mental Health Code, and Michigan Medicaid policy mandate that appropriate amount, scope and duration is to be determined through the person-centered planning process. It is indisputable that the federal regulations, state law, and policy, require the cooperation of both the Community Mental Health and the Medicaid beneficiary in the person-centered planning process.

The CMH and the Medicaid beneficiary are bound by the Code of Federal Regulations, the state Mental Health Code, and state Medicaid policy. As such, both parties must cooperate in the development of a person-centered plan before Medicaid services can be authorized.

> MCL 330.1712 Individualized written plan of services.
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> (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.
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> (2) If a recipient is not satisfied with his or his individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
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> (3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

The CMH must follow the Department's Medicaid Provider Manual when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply. The Medicaid Provider Manual sets out the eligibility requirements as:

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.
- Documented in the individual plan of service.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, January 1, 2011, page 13.

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.

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) (emphasis added by A LJ)

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.

The CMH determined that the Appellant did meet medical necessity criteria to have an authorization of 47.5 hours of Community Living Supports (CLS) authorized each week. He and his mother assert the amount and scope of services rendered are inadequate. The *Medicaid Provider Manual, Mental Health/Substance Abuse S*ection articulates Medicaid policy for Michigan, specifically including CLS.

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 is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

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

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and nonmedical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal

> Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. (Underline emphasis added by ALJ).
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> *MPM, Mental Health and Substance Abuse Section, December 1, 2010, Page 100.*

The CMH presented the position that the CLS authorization is adequate to meet his needs at this time. It was asserted that he is not alone while in school, which is expected to be full time during the school year. It was recognized that historically he has had health issues that prevented him from full time consistent school attendance. This was based upon past medical history, surgical needs, which were exacerbated by complications resultant from surgery. After school hours he has authorization for staff to be present for over 6 hours per day. His remaining needs for monitoring are met by natural supports provided by his mother. The CMH asserts this is adequate to meet the goals identified in his IPOS. Testimony and evidence was taken concerning each goal identified in the IPOS. The CLS authorization targeted towards each goal was identified at hearing. The exhibits entered into evidence by the CMH supported their position that each goal identified in the IPOS has an authorization adequate to reasonably achieve that goal.

The Appellant's mother, through the Appellant's attorney asserts the CLS is inadequate to address his needs when he is ill, which is frequently. It was asserted his health needs are such that her job is placed at risk for having to be absent from work in order to stay home, supervise him and meet his medical needs. It was asserted that she should not be responsible to meet over half of his needs in order for him to remain living in the family home. She asserted that she is able and willing to provide the 8 hours of supervision he requires at night time. She further asserts she is at risk of losing her job and home if the Appellant is not provided sufficient supports to address his medical need for 24 hour supervision. She expressed a great deal of frustration with Community Mental Health, the Appellant's former day care, school system, hospital systems and service providers in her written statement, which was read into the record.

The Appellant read his own written statement/testimony into the record at hearing. He expressed frustration at his medical condition and asserted the authorization from CMH is inadequate to meet his medical needs without imposing on his mother to such an extent her job is threatened. He described his daily experience with pain and lack of desire to have care provided by his father due to the physical discomfort of his cold house. He described having only a mattress on the floor to sleep on at his father's home, which is uncomfortable for him. He further described having 2 recent surgeries and enduring pain which causes him to miss school.

The documentation submitted into the evidentiary record was read and considered carefully by this ALJ. Despite the abundance of testimony at hearing, the legal issues in the case can be distilled rather simply. Is the Appellant's medically necessary need for supervision and

monitoring his health adequately met with the authorization of 47.5 hours CLS per week? In order to determine this, the Appellant's particular circumstances must be considered. This consumer of CMH services has a relatively high need for monitoring based upon his historical health record. Although he is still eligible for full time school, it is uncontested he does not actually attend full time and has not during the past 2 years of surgery and complications resultant there from. Additionally, he resides with his mother in the family home, where she is the sole live-in care taker. She works full time outside the home and is desirous of participating in her own chosen activities as well. The parties stipulate the Appellant's medical needs are such he requires 24 hour supervision. How much supervision is the responsibility of the CMH and how much is the responsibility of his mother is disputed. This ALJ finds the authorization of CLS is adequate when the Appellant is healthy and able to attend school as scheduled.

The fact the Appellant does not actually attend school full time cannot be ignored, however. This ALJ read the documentation submitted by the CMH to determine whether the fact that the Appellant does not actually attend school full time is considered by CMH in making the determination of CLS authorization. There is no authorization addressing his frequent absences from school. There was evidence at hearing that there have been times when additional CLS was authorized outside of what was identified in the IPOS in this particular case, in order to address needs while a Home Help Services application was pending. It is asserted this could be done to address school absences if an actual emergency arose and the Appellant did not have CLS authorization available for use. It was further asserted his past utilization has fallen below authorized levels, thus there is no need for additional CLS to be authorized. It is an uncontested fact that the Appellant's recent history indicates he does not attend school full time, whether he is expected to or not. It is not proper for this ALJ to attempt to make a legal determination of whether the Appellant properly or improperly misses school. There is a lot of uncontested evidence the Appellant has medical issues, is exhausted, suffers headaches and is experiencing mental health issues at this time. This ALJ cannot order the Appellant to actually attend school. Therefore, what is left to determine is where the responsibility falls.

Evidence of record was submitted by the CMH that recent historical use of CLS authorization has been between 1400-1700 hours per year. This evidence was objected to by counsel for Appellant. The objection is overruled because past utilization is relevant. Counsel for Appellant asserts utilization has been affected by lack of access to qualified, willing staff. It is asserted staff is unwilling to be only on call to come when the Appellant realizes he does not feel well enough to attend school. Even if found true, the lack of willing staff to be placed on call is not evidence of an inadequate authorization for CLS. It is inappropriate to schedule staff to be present during the time when the Appellant would normally attend school. This ALJ finds it is normally reasonable to develop an IPOS with an assumption that a person eligible for full time school attendance will attend (thus having supervision during that time). However, in this particular circumstance, it is evident the Appellant does not actually attend school full time, thus it is appropriate to fail to address this in his IPOS. Here, past utilization is demonstrative that the CLS has been adequate to address the need when staff is willing to be placed on call. The evidence of record from the Appellant's mother is that despite past extreme difficulties, she currently has a qualified staff person willing and able to be on call for the Appellant.

Additionally, despite having expressed extreme anxiety about job loss and an inevitable result of homelessness caused by job loss, upon cross examination, the Appellant's mother admitted she has not been counseled or disciplined by her employer for absenteeism as of the hearing date. This ALJ takes the Appellant's mother's concerns about job performance and meeting responsibilities quite seriously; however, they are not fully persuasive at this time given the lack of evidence supporting the claim that job loss and homelessness are realistic and/or imminent.

This ALJ believes the CMH should address the actual circumstances of the Appellant when developing the IPOS, in accordance with the requirements of the Michigan Mental Health Code. This Appellant has a history of high medical needs that result in high service requirements. While it is true that normally parents are responsible for their children when they do not attend school, in this unique case the child is an adult and is unable to be left unmonitored. His parents are correctly identified as natural supports at this time in his life, not his sole supports. It is appropriate to authorize some CLS for emergent situations in the particular circumstances evidenced in this case, given the Appellant's recent medical history.

Evidence of recent past utilization shows the CLS available is adequate to address the Appellant's needs, despite a lack of explicit authorization solely for health and safety monitoring during school absence in the IPOS. The implication drawn from the lack of explicit authorization of CLS for this purpose is that it falls to the Appellant's natural supports. This is not unreasonable. The Appellant has expressed that he does not prefer to be in the care of his father, leaving only one natural support. Her lack of willingness or ability to accommodate the Appellant's desire for her to be his care provider when he feels too ill to attend school does not evidence there is a lack of appropriate CLS authorization in the opinion of this ALJ. It may be better evidence of a failure to locate adequate staffing resources willing to work on-call. It may evidence an unworkable living arrangement for the Appellant and his mother. That must be worked out between them. The utilization records are good evidence the Appellant's needs are able to be met and reasonably achieve the goals set forth in the IPOS.

The testimony of [redacted] is that additional supports services can be authorized as necessary. Furthermore, it is asserted if additional supports are needed on a more permanent basis provision of them may require a change in the Appellant's residence. This ALJ concurs.

It is clear from the record the need for school day monitoring is there and has not been explicitly addressed in this adult's IPOS. Despite not being explicitly set out as a goal that must be addressed, the evidence of record supports a finding his actual use of CLS is such that the authorization set forth is adequate at this time. This ALJ has considered that the Appellant is experiencing mental health issues according to the evidence of record. But school attendance has not been demonstrated to exacerbate them or prevent treatment of them. There is insufficient evidence of record to find the actual authorization of CLS is inadequate to meet the Appellant's needs, despite the lack of explicit dedicated hours for school absence.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law,

decides that the Appellant's overall authorization of CLS hours is adequate to meet his needs based upon recent past utilization.

IT IS THEREFORE ORDERED that:

The CMH decision to deny additional CLS services is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/20/2011

***** 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.