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. 2011-14675 CMH
Case No. 16191487

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], Appellant's [redacted], appeared on behalf of the Appellant. [redacted], appeared and provided testimony.

[redacted] (CMH), represented the CMH. [redacted], and [redacted], appeared as witnesses for the Department.

ISSUE

Did the CMH properly terminate the Appellant's 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), as a person with serious and persistent mental illness.

2. 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.

3. The Appellant is [redacted] Medicaid beneficiary. The Appellant is diagnosed with schizoaffective disorder. (Exhibit 1, page 21).

4. The Appellant lives in an adult foster care home owned by his representative at hearing. (Exhibit 1).

5. Appellant's [redacted] is one of Appellant's paid CLS providers. (testimony).

6. In Appellant's [redacted] individual plan of service, the goals set for Appellant were:

> (Appellant) will complete bathing with no more than initial setup, verbal prompts and physical assistance to wash body parts 100% of trials, for 12 of the next 12 consecutive months.
>
> (Appellant) will continue to complete dressing with no more than initial setup, verbal prompts and minimal physical assistance to put on shoes, socks, shirt, belt 100% of trials, for 12 of the next 12 consecutive months.
>
> (Appellant) will continue to complete his shaving with no more than initial set up, verbal prompts and partial physical assistance to ensure thoroughness, 100% of trials, for the next 12 of the next 12 consecutive months. (Exhibit 1, pages 16-17).

7. In Appellant's [redacted] individual plan of service, the Appellant's medical history listed "no apparent physical limitations." (Exhibit 1, page 23).

8. In Appellant's [redacted] individual plan of service the CMH authorized the following Medicaid services: CLS at a level 2, skill building services, supports coordination, and an occupational therapy evaluation. (Exhibit 1, page 19).

9. The Appellant does not currently have a behavioral treatment plan. (Exhibit 1, and testimony).

10. The Appellant does not have a [redacted] occupational therapy plan.

11. On [redacted], an audit was conducted for CMH clients with the sole diagnosis of mental illness and the lowest levels of need (level 1 and level 2), for whom CMH authorized CLS services be provided by his or her adult foster care staff. (Exhibit 1, pages 1-5).

12. On [redacted], the CMH sent a notice to the Appellant notifying him that the CLS hours would be terminated because his "needs can be met in general AFC." (Exhibit 1, page 6).

13. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on [redacted]. (Exhibit 2).

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 scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Appellant, which includes review of medical documentation, to determine what Medicaid services are medically necessary and to determine the amount or level of Medicaid medically necessary services that are needed to reasonably achieve his goals. The federal regulation mandate extends to medical necessity for CLS in an adult foster care home.

In this case, the CMH terminated the CLS that was being provided to Appellant by his [redacted]. As such, what is being disputed is whether the assisting, reminding, observing, guiding and/or training for the activities of daily living bathing, dressing, and personal hygiene was nearly minimal supervision or whether it rose to a level of Medicaid-funded CLS services.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid mental health policy for Michigan. It defines community living supports as:

> **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:
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> - 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).
>
> *MPM, Mental Health and Substance Abuse Section, December 1, 2010, Page 100.*

Witness [redacted] testified that in order for CMH to process an authorization request an assessment is completed. In Appellant's case, witness [redacted] testified that an assessment was performed for Appellant on [redacted]. (Exhibit 1, page 20).

The Appellant's witness [redacted], testified that a CMH case audit was performed on [redacted], for CMH clients with the sole diagnosis of mental illness, and the lowest levels of need (level 1 and level 2), for whom CMH authorized CLS services be provided by his or her adult foster care staff. (Exhibit 1, pages 1-5). Witness [redacted] noted that the Appellant's medical history showed "no apparent physical limitations." (Exhibit 1, page 23). Witness [redacted] further noted that the CMH also reviewed the individual plan of service as part of the audits:

- (Appellant's) will complete bathing with no more than initial setup, verbal prompts and physical assistance to wash body parts 100% of trials, for 12 of the next 12 consecutive months.

- (Appellant) will continue to complete dressing with no more than initial setup, verbal prompts and minimal physical assistance to put on shoes, socks, shirt, belt 100% of trials, for 12 of the next 12 consecutive months.

- (Appellant) will continue to complete his shaving with no more than initial set up, verbal prompts and partial physical assistance to ensure thoroughness, 100% of trials, for the next 12 of the next 12 consecutive months. (Exhibit 1, pages 16-17).

Witness [redacted] explained that the evidence the CMH had demonstrated the Appellant needed a minimal amount of prompting and minimal physical assistance to perform his activities of daily living, and that was evidence that the Appellant's care in the [redacted] was nothing more than minimal supervision.

The CMH representative stated that minimal supervision is included in the adult foster care per diem, and that community living supports in Appellant's case was not needed because the Appellant's goals required the minimal level of care. The CMH [redacted] and the CMH

[redacted] clarified that assisting, reminding, observing, guiding and/or training for activities of daily living might be paid for either in the adult foster care per diem or by the community mental health Medicaid depending on the level of assisting, reminding, observing, guiding and/or training needed. The CMH [redacted] and the CMH [redacted] further clarified that the evidence the utilization management staff possessed in this case at the time of the audit showed only the minimal amount of supervision was needed for the Appellant to successfully perform his activities of daily living and therefore there was no medical necessity justification for community living supports to be paid for by CMH Medicaid funds.

Appellant's [redacted] testified that although the Appellant had not recently seen a CMH psychiatrist, his mental health medication, Clozaril, continues to be prescribed by his primary care physician. The Appellant's [redacted] testified that the Appellant needs guidance and assistance while choosing his clothing so that he won't select soiled clothing to wear. The Appellant's [redacted] also said that the Appellant needs prompting to ensure thorough bathing. The Appellant's [redacted] also testified that she believes the Appellant should have a behavioral plan in place because the Appellant has a lack of fine motor skills and can become agitated when he cannot perform a task because of a lack of fine motor skills.

The task before this administrative law judge is to review the document and testimony evidence admitted into the record, weigh the evidence, and apply it to policy.

The *Department of Human Services, Adult Services Manual, ACP, Program Procedures*, sets forth the policy definitions for personal care services and distinguishes it from domiciliary care.

> **DEFINITIONS PERSONAL CARE SERVICES** (for Title XIX payments) – Personal care services are funded by Title XIX for Medicaid recipients. Below are definitions of personal activities of daily living.
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> **Personal Activities of Daily Living:**
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> • **Eating/feeding** - is the process of getting food by any means from the receptacle (plate, cup, glass) into the body. This activity describes the process of eating after food is placed in front of an individual.
>
> • **Toileting** - is the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes. A commode in any location may be considered the toilet room only if in addition to meeting the criteria for toileting the individual empties, cleanses, and replaces the receptacle without assistance from another person(s).

• **Bathing** - is the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment whether this is in bed, shower, or tub.

• **Grooming** - is the activity associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.

• **Dressing** - is the process of putting on, fastening, and taking off all items of clothing, braces, and artificial limbs that are worn daily by the individual including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or gowns with robe and slippers as their usual attire are considered dressed.

• **Transferring** - is the process of moving horizontally and/or vertically between the bed, chair, wheelchair, and/or stretcher.

• **Ambulation** - is the process of moving about on foot or by means of a device with wheels.

• **Assistance with self-administered medication** - is the process of assisting the client with medications which are ordinarily self administered, when ordered by the client's physician.
Note: Residents in an Adult Foster Care Home (AFC) or Home for the Aged (HA) are in need of personal care services even if the only assistance needed is verbal prompts. **Verbal prompts** are a **level 2** on the **needs assessment. Levels 3, 4, or 5 should be used if they accurately reflect the personal care needs of the client.**

DOMICILIARY CARE (for SSI or SDA Payment) -- Room, board and minimal supervision.

PERSONAL CARE
Confusion frequently arises because of the 3 different definitions of personal care. Each is described below to clarify the differences.

• **SSI/SDA personal care** establishes the basis for authorizing a payment rate for the client. For this purpose, personal care means need for assistance with activities of daily living (ADL), supervision of medication, or supervision because of extensive behavior problems in addition to room and board.

> • **MA personal care** establishes client eligibility for a provider payment. For this purpose, personal care means the need for assistance with ADL, including verbal prompts or supervision of medication. Consequently clients can be eligible for and receive SSI personal care rate because of behavior problems and not be eligible for MA personal care.
>
> • **AFC Licensing** definition of personal care establishes an expectation for Adult Foster Care licensees. For this purpose personal care means personal assistance provided by the licensee or an agent or employee of the licensee to a resident who requires assistance including guiding and directing, with dressing, personal hygiene, grooming, maintenance of a medication schedule as directed and supervised by the resident's physician, or the development of those personal and social skills required to live in the least restrictive environment. Consequently, a resident may be appropriate for care in an AFC facility and be ineligible for both SSI at the personal care rate and MA personal care.
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> *Adult Services Manual, ACP, Program Procedures, 1-1-2010, pp 1-2.*

This administrative law judge applied the document evidence as found in the individual plan of service and in the [redacted] psychosocial assessment. It is noted that there is no occupational assessment that is part of the record, nor is there a behavioral plan as part of the record. The Appellant's [redacted] acknowledged that there is no behavioral plan which would set forth an obligation for the [redacted] or the CMH to provide more than minimal supervision to Appellant.

This administrative law judge is limited to the evidence the community mental health had at the time it made its decision. The evidence the CMH had in its possession was that the Appellant needed nothing more than initial set up, verbal prompts, and partial physical assistance for bathing, dressing, shaving, and oral care. Applying the evidence the CMH had at the time it made its authorization decision in [redacted] supports the CMH position that Appellant was not able to demonstrate medical necessity for CLS above the minimal supervision provided in the [redacted] per diem.

The Appellant bears the burden of proving by a preponderance of the evidence that the previous authorization of CLS was medically necessary to reasonably achieve the Appellant's CLS goals. The Appellant did not meet his burden to establish medical necessity above and beyond the minimal supervision provided by the [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly terminated the Appellant's CLS.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/28/2011

***** 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.