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. 2011-25147 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]. [redacted], attorney, appeared on behalf of the Appellant. Her witnesses were the Appellant's mother/guardian, [redacted] and [redacted], care giver. The Appellant was present for hearing, but did not testify. [redacted], Fair Hearings Officer, represented the Department. Her witnesses were [redacted], Program Supervisor, [redacted], Assistant Utilization Coordinator and [redacted], Supports Coordinator.

PRELIMINARY MATTER

For unknown reasons the page numbering of the Department's exhibit in the upper right corner of each page is not in sequence, although it was faxed and received in sequence. The reader is re-directed to the lower right hand corner of each page for accurate renumbering as provided by the ALJ.

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 Exhibit #1.

2. The Appellant is identified an adult male with severe mental retardation, CP, scoliosis, seizure disorder and cataracts. He is blind in his left eye. Department's Exhibit A, p. 22.

3. The Appellant has a scored-IQ of <35 and is found to be functioning in the severe range of mental retardation. He "…exhibit[s] aggressive behaviors toward himself and others at times." Department's Exhibit A, p. 3.

4. In the person centered plan, clinician [redacted] concludes that the Appellant, because he is "…out in the community more with his CLS staff, it appears that [redacted] is beginning to say more individual words." His mother reports better communication and personality since he has left school. Department's Exhibit A, p. 4.

5. The Appellant receives service from the [redacted] Community Mental Health Authority [redacted] CMHA) via its contractor, [redacted] Department's Exhibit A, p. 1.

6. On an unknown date the Appellant received notice advising of his pending decrease in CLS from 12-hours a day to 9-hours a day.[1] Department's Exhibit A, p. 1.

7. The Appellant's CLS was reduced based on Functional Assessment Tool (FAT) wherein it was determined that the Appellant scored as eligible for only 9-hours of CLS, instead of his previous 12-hours as recommended in his person centered plan. Department's Exhibit A, pp. 3, 4, 7 and 42 and see Testimony of [redacted].

8. The FAT tool presented for evidence is barely legible and is missing introductory pages as well as SCA supervisory signature. The blank signature line appears over the instruction "NOTE: A copy of the Individualized Plan of Service (IPOS) Adequate Notice of Action for Medicaid Fair Hearing and Local Appeal Rights form must be completed and shared with the person/guardian whenever the plan is amended." Department's Exhibit A, pp. 1-46.

9. The Department has determined on FAT assessment that the Appellant only requires 9-hours daily of CLS. Department's Exhibit A, p. 42.[2]

10. The Department currently provides the Appellant with supports coordination and CLS. (Department's Exhibit A, p. 6)

11. The Appellant requested an administrative hearing before the Michigan Administrative Hearing System for the Department of Community Health on [redacted], after acknowledging receipt of Advance Notice from [redacted] [unknown date] advising that the Appellant's CLS would be reduced for lack of medical necessity. (Appellant's Exhibit #2)

[1] See also, Appellant's Exhibit #2.
[2] Actually, it refers the reader to Adult Family Home CLS Authorization Guidelines [not provided] for hours corresponding to certain levels. *Supra* page 35.

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) and 1915(c) Medicaid Managed Specialty Services waiver. [redacted] Community Mental Health Authority (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.

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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
> - 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

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

> 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

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The Department witnesses testified that the Appellant's grant of CLS was reduced following FAT assessment wherein he was determined to be at "Level 3." Hours were then assigned based on this scoring methodology and were "backed out or deducted" from his CLS total. The witness testified that the Appellant was "right on the edge" between level two and level three – so a determination was made to grant one additional point for behavior – which translated into marking the rubric of mild behavior on Department's Exhibit A, at page 26.

On cross examination the witness acknowledged that the FAT tool was not a measuring device based on law. He stated that the IPOS dictated services. He said the tool is a guide for assessment of needed services. 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 can provide – although he could not articulate an answer to the question of how many hours the Appellant's mother/guardian was supposed to provide.

The Appellant's mother testified that the Appellant cannot be left alone and that he still engages in self abusive behavior including sucking on hands, hitting and pounding his head. She said he was not independent in toileting and seldom slept through the night. On cross examination the witness said that his cognition was not mild – but moderate.

The testimony of Appellant's witness [redacted] reinforced the Appellant's moderate cognition level while the Department's supporting witness [redacted] agreed that the Appellant could not be left alone.

On review the Department's case fails on several levels; first with regard to the FAT tool found at Department's Exhibit A, pages 23-36 – the scoring found in this document did not line up with the testimony of their witness. The witness clearly said that the Appellant was at Level 3 after adjusting for behavior which – according to their own assessment tool – would place the Appellant in the next highest category for CLS. [*See* Department's Exhibit A, at page 35]

> ● Further aggravating the decision reached on FAT assessment is when the tool is compared to Appellant's Exhibit #4 – the scoring result is different, yet the documents are presented as copies of the same document. *See* Appellant's Exhibit #4 at page 14. As for the extra assessment point awarded the Appellant for challenging behaviors "mild" I do not believe the evidence supported that number – it clearly required a higher ranking based on the evidence and testimony.
>
> ● I found the Department's Exhibit A – [the FAT tool at pages 23-36] to be incomplete and untrustworthy in light of the contradictory testimony of the Department's witness and when further compared to Appellant's Exhibit #4.[4]
>
> ● Next, the Department witness testified that revised hours were achieved "by deduction from the total" – versus coordination with other services. Thus, the Department's decision to rely solely on the FAT tool resulted in a subjective determination [loss of CLS] unsupported in either the IPOS or PCP. *See* Appellant's Exhibit #1 – throughout.
>
> ● Finally, although Appellant's counsel acknowledged receipt of notice [at some point in the proceedings] there was no proof of service/notice, proposed effective date or listing of possible exceptions to notice in the Department's proofs.

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 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 12-hours of medically necessary CLS. This was the appropriate scope, duration and intensity of service reasonably necessary to achieve his goals and the purpose of the covered service - which was supported by the evidence and the testimony.

The conclusion relied upon by the Department on FAT assessment represented a subjective estimate and erroneous conclusion not supported by either the evidence or the testimony.

The Appellant has a person centered plan and is meeting his stated goals with 12-hours of CLS and supports coordination. 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 reduction of CLS was not supported in this record. The Appellant has preponderated his burden of proof.

[4] These were supposed to represent the same document – yet the Department's exhibit was missing 3 pages, had a different total score [lower] and lacked authorizing signatures.

The Department's decision to reduce CLS from 12-hours a day to 9-hours a day was neither supported in the record nor based on reduced medical necessity.

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: 9/30/2011

***** 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.