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:

Docket No. 2011-32431 CMH
Case No.

Appellant
______________________/

DECISION AND ORDER

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

After due notice, a hearing was held on The record was left open to receive certain items of evidence by fax. The record closed on receipt of that last item on . The Appellant was represented by her adoptive mother, Her witnesses were, and . , Fair Hearings Officer, represented the Department. His witness was , Director of Care Management.

Also in attendance were two (2) unsworn and unidentified CMH observers.

PRELIMINARY MATTER

At the threshold of hearing the ALJ took the admission of Appellant's (proposed) Exhibit #2 under advisement – the document had not been shared with the Department's representative until the hearing began. The document was compiled by , Supports Coordinator, and contained 48 pages of assorted documents and reports [without page numbering or indexing] concerning the Appellant. [The highlighting and marking on the pages were preexisting on receipt by the Michigan Administrative Hearing System.]

During the course of the hearing the parties attempted to locate a report concerning the Appellant within Appellant's (proposed) Exhibit #2 from the . It was described to the ALJ as having a " on the stationary. No such document appeared nor could the ALJ locate it in the sheaf of papers presented by the Appellant. The ALJ instructed the Fair Hearings Officer to circle the date of specific report and fax it to the Michigan Administrative Hearing System post hearing – so questioning could resume between the parties without further delay. The request was completed following the hearing.

Appellant's Exhibit #2 is admitted without objection.

Further along in the Department's examination of the Appellant's witness the Fair Hearings Officer accessed a document described as an IEP – which was referenced as having been reviewed by his witness, , but was not shared with the Appellant prior to hearing. The Fair Hearings Officer mistakenly stated that it was contained within Appellant's (proposed) Exhibit

#2. On receipt of this document post hearing it was compared with the contents of Appellant's Exhibit #2 – no such document appeared. There was a "multidisciplinary evaluation report" from the school starting at page 20 of Appellant's Exhibit #2.

● The IEP, with the exception of the witness [redacted] reference to same during their assessment review, was not admitted and the questions and answers surrounding this document are stricken from the record.

● On post hearing review of Appellant's Exhibit #2 the report from the [redacted] ultimately reached this ALJ in two distinctly different versions. Further review showed that the content of the reports to be identical, but the pagination, type font, presentation, etc., were different and impossible to distinguish during a telephone hearing.

● This post hearing document [[redacted] logo/report] is marked and entered into the record as Joint Exhibit #3.

● In her post hearing pleading the Appellant's representative reported the above concerns. She also stated that "a pile of paperwork" was submitted and some that was not submitted [into evidence] was handed to the Fair Hearings Officer by [redacted]" and that the status of those documents was made clear to the Department's representative at hearing. There was no such testimony during the course of the hearing and the ALJ was not made aware of the presence of [redacted], Supports Coordinator, or her role in the hearing – if any.

The Department is reminded that the ALJ can consider only that evidence and sworn testimony which appears in the record. And the Appellant's representative is reminded that she is responsible for producing her own exhibits.

The record was closed on receipt of the documents requested by the ALJ on [redacted].

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 Medicaid beneficiary receiving services through [redacted] Community Mental Heath Authority (CMH). (Appellant's Exhibit #1)

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

3. The Appellant is diagnosed with PTSD, Mild Mental Retardation, auditory processing disorder, autism, sensory processing disorder, anxiety, depression,

seizures and migraines. (Department's Exhibit A, p. 1 and Appellant's Exhibit #1, p. 1)

4. The Appellant lives with her adoptive mother and biological sister. The adoption was finalized [redacted]. (Department's Exhibit A, p. 1)

5. The Appellant's representative claims that the adoption was finalized on [redacted]. (Appellant's Exhibit #2, p. 18)

6. Appellant's mother is her primary caregiver. (Department's Exhibit A - throughout and *See* Testimony).

7. The Appellant's representative alleges that the decision to reduce CLS is driven by funding and not the needs of the Appellant. (Appellant's Exhibit #1, p. 2)

8. Following assessment the CMH proposed reduction in the Appellant's CLS from 19-hours per week to 4-hours per week with an effective date of [redacted]. (Department's Exhibit A, pp. 1, 6)

9. The CMH reviewer(s) determined that the Appellant's needs as reflected in her Person Centered Plan were best met by family, school and other remaining services provided by the CMH. (*See* Testimony of [redacted] and Department's Exhibit A, p. 3)

10. During their review the CMH noted that some of the tasks which Medicaid paid were the responsibility of a parent to provide.

11. The Department witness [redacted] also explained that there was concern – given the circumstances unique to the Appellant – that the high level of staffing would hinder development of the parent-child relationship in this new adoption. (*See* Testimony of [redacted] and Department's Exhibit A, p. 3)

12. The Appellant was notified by "advance notice" on [redacted], of the proposed reduction in CLS. Her further appeal rights were contained therein. (Department's Exhibit A, pp. 3, 6, 7)

13. The Michigan Administrative Hearings System for the Department of Community Health received the instant request for hearing on [redacted]. (Appellant's Exhibit #1).

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 she 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. Saginaw County Community Mental Health Authority (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 Medicaid Provider Manual, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity 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 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.

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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.
>
> MPM, *Supra* pp. 106-107

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At hearing the Department witness established that the Appellant's goals as recited in the PCP could be met with substantially fewer CLS hours – particularly in light of the comprehensive array of other CMH services still extant. [See Department's Exhibit A, at page 6] Even with the reduction proposed by the CMH reviewer the Appellant still receives 1470 units of assorted CMH services.

Witness [redacted] explained that CMH services remained medically necessary, but in a lesser amount based on their review, conducted by mental health professionals, of the Appellant's Person Centered Plan and her IEP.[1] [redacted] concluded her assessment stating that medical records, review of assessments, contact with outside sources and supports coordinators helped to form her conclusion that no other services could accomplish the goals established for the Appellant. She added that the preexisting amount of CLS was, in fact, a hindrance to the child-parent bonding process owing to the extra ordinary number of employees required to staff a 19-hour CLS assignment. She said this would be confusing to the child.

Both the reduction of CLS and the conclusions articulated by [redacted] were dismissed by the Appellant's representative who described herself as "…a single parent with two children and no family." [*See* Appellant's Exhibit #1, at page 2]

The Appellant added that she was not prepared to meet the high level of need presented by her adoptive daughter. She said the amount of services she received from the school system is not enough to reinforce learning in her memory impaired daughter.

The bulk of the her daughter's learning difficulty stems from her belief that the Appellant suffers from autism - which exacerbates her short term memory and requires a process of repetition for learning basic tasks.

The Appellant's witness, [redacted], testified that the Appellant displays the characteristics of autism in the home.

Community Living Supports (CLS) at 19-hours a week did present as a highly staffed environment, but the Appellant's argument that the CMH was making cuts in services owing to cost was not supported, by her, with any evidence at hearing.

[1] Neither the PCP nor the IEP were entered into evidence.

A point of contention between the parties was whether or not the Appellant had a diagnosis of autism. The CMH witness said there was no such diagnosis while the Appellant's representative said there was such a diagnosis. The school based assessment rejecting a diagnosis of autism also contained a further assessment conducted by Robert White, LMSW, who recommended treatment for both the Appellant and her representative – for issues related to PTSD.[2]

On review of the various assessments I found the school-based assessment to be competent evidence and credible in its conclusions – what possible goal would be achieved by labeling a cognitively impaired individual as further impaired with Autism when credible evidence supports a different conclusion?

The answer to that question touches upon proxy issues and goals not related to the Appellant – but rather to well-intended others. While the issue of excessive staffing was cautioned by the CMH as a potential deterrent to the child-parent bonding experience the wisdom of the policy manual regarding the provision of B3 services cannot be understated based on this record.

> **[ ] 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.…
>
> MPM, *Supra*, page 103

The Appellant argues for additional CLS to insure repetitive drill for the Appellant, while the CMH fears excessive staffing would interfere with the bonding function common to the parenting experience – regardless of a child's disability. The Department witness, based on these facts, credibly opined that the Appellant's needs were sufficiently addressed with CLS at 4 hours per week.

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[2] Appellant's Exhibit #2 at page 48. The report from [redacted], also documented the need for temporarily increased parental involvement with the Appellant's daily self-care routines.

The Appellant's representative testified at some length about "her goals" for the future of the Appellant, however she failed to preponderate her burden of proof that the CMH decision to reduce CLS was reached in error; was not based on a review of medically necessary services or that it was impermissibly reached "… based on [ ] cost."[3]

On review, the Department's CLS calculation is supported by medical necessity and is levied in the appropriate amount, scope and duration consistent with the coordinated services offered by the school, the family and the Appellant's remaining CMH services.

This Administrative Law Judge must follow the CFR and the state Medicaid policy, and is without authority to grant CLS hours out of accordance with the CFR and state policy.

The CMH is mandated by federal regulation to perform an assessment of the Appellant to determine what Medicaid services are medically necessary and to determine the amount or level of medically necessary services needed to achieve her goals.

The Appellant's PCP is not a static instrument and over time it will likely reflect changes in necessary supports for the Appellant - when those changes are manifest. Today the Appellant's proofs do not preponderate the medical necessity for reinstatement of 19 [weekly] hours of CLS or that the reduction to 4-hours of CLS per week was reached in error.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's services to 4 CLS hours per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

cc:

Date Mailed: 8/4/2011

[3] MPM, Medical Necessity, §§2.5.A – D. Mental Health [ ], April 1, 2011, pp. 13, 14

***** 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.