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. 2012-23911 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 held on [redacted]. [redacted], Appellant's mother, appeared on behalf of the Appellant.

[redacted], Assistant Corporation Counsel, [redacted] (CMH), represented the Department. [redacted], Ph.D., CMH Access Center Manager, appeared as a witness for the Department.

ISSUE

Did the CMH properly determine that Appellant did not meet the criteria for residential placement?

Did the CMH properly determine Appellant's community living supports (CLS) and respite 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 Macomb County Community Mental Health (CMH).

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 a [redacted] year-old Medicaid beneficiary whose date of birth is [redacted]. The Appellant is enrolled in commercial insurance and in fee-for-service Medicaid, but is not enrolled in any of the specialty Medicaid

Waivers. (Exhibit C)

4. The Appellant is diagnosed with bipolar disorder, cognitive impairment secondary to Full Scale IQ sore of 58, and phenylketonuria (PKU). Historical references to other diagnoses are present, including attention deficit hyperactivity disorder, conduct disorder and pervasive developmental disorder NOS. Appellant has been prescribed Lithium, Abilify, Adderal, Tofranil, and Cogentin. (Exhibit D).

5. The Appellant lives with his mother and sister. (Exhibit D, page 48).

6. Appellant's mother is his primary caregiver. Appellant is in general education and special education at New Haven High School. (Exhibit D, p 48).

7. In Appellant's Person Centered Plan (PCP) dated [redacted] the CMH recommended the following Medicaid services: supports coordination, psychiatric assessment, neurological evaluation, behaviorist services, counseling, community living supports, respite care, and a residential program with appropriate therapy. (Exhibit E, p 53).

8. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying him that his request for long-term residential placement had been denied because the Appellant did "not meet criteria for services requested." The notice included rights to a Medicaid fair hearing. (Exhibit A).

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying him that his request for 40.5 CLS hours per week had been denied as not medically necessary, but that 20 hours per week had been authorized. Appellant was also informed that his request for 20 hours per week of respite had been denied, but that 12.5 hours per week of respite had been approved. The notice included rights to a Medicaid fair hearing. (Exhibit A).

10. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit B).

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*

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.*

[redacted], Ph.D., CMH Access Center Manager, has a doctorate degree in psychology and she reviewed all of Appellant's records prior to the hearing. With regard to long-term residential treatment, [redacted] testified that the Michigan Medicaid Provider Manual does not have a section describing such care, but that CMH can purchase such care through a combination of community living supports and personal care services. However, [redacted] pointed out that such care would not be considered medically necessary if the child can be maintained in the community with sufficient community-based services. [redacted] testified that the Access Screening of [redacted], contains an extensive discussion of community-based services that can support the Appellant in the community, such as out-of-home respite care. In that program, children can stay overnight for a series of nights and staff can assist the children with getting to school when school is in session. [redacted] indicated that Appellant has attended this program in the past and, despite some difficulties there, he is still authorized to attend the program. [redacted] testified that, in her professional opinion, Appellant does not currently meet the medical criteria for long-term residential placement and that he can better be served in a less restrictive, more integrated setting in the community.

With regard to CLS hours, [redacted] testified that in her professional opinion, the 20 CLS hours per week authorized were sufficient to meet the goals contained in Appellant's Person Centered Plan. [redacted] also pointed out, as discussed in more detail below, that CLS hours are not intended to provide all care for a child as the parent is expected to provide care to a child with a disability in a similar fashion to that for a child without a disability. With regard to respite hours, [redacted] testified that the 20 respite hours per week requested was excessive, especially given the fact that Appellant is also entitled to out-of-home respite hours, which are calculated separately. [redacted] testified that in her professional opinion, the 12.5

hours per week of respite approved are sufficient in amount, scope and duration to meet Appellant's needs.

The Appellant's mother testified that Appellant is physically aggressive and violent on a daily basis and that she has been forced to move her daughter out of the family home over concern that Appellant will physically or sexually abuse her. Appellant's mother testified that having Appellant in the family home is a health and safety issue and that she will give up custody of her son before she will put her and her family at risk. Appellant's mother also testified that they have tried behavioral plans in the past, to little effect. Appellant's mother indicated that if Appellant is not provided 24 hours per day/7 day per week staffing, be is going to end up in jail on a domestic violence charge.

The *Medicaid Provider Manual, Section 2.5* lists the Medical Necessity Criteria:

> **2.5.A. Medical Necessity Criteria**
>
> **Mental health, developmental disabilities, and substance abuse services** are supports, services and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.
>
> **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/aids) who know the beneficiary; and
> - Based on clinical information from the beneficiary's primary care physician or health care professions with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on personal-centered planning, and for beneficiaries with substance use disorders, individuals 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.

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 the 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. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports 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, fate-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.

MPM, Mental Health/Substance Abuse Section
January 1, 2012 pages 12-14.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to B3 supports and services:

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.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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) who 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.

* * *

MPM, Mental Health and Substance Abuse Section,
January 1, 2012, Page 105-106.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to community living supports:

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).

MPM, Mental Health and Substance Abuse Section, January 1, 2012, Page 108-109.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard respite:

17.3.J. RESPITE CARE SERVICES

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid primary caregiver (e.g., family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for

> community living support or other services of paid support/training staff.
>
> *MPM, Mental Health and Substance Abuse Section, January 1, 2012, Page 118-120.*

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

Applying the facts of this case to the documentation in the annual assessment and person centered plan supports the CMH position that Appellant does not meet the medical criteria for long-term residential placement and that the authorized CLS and respite hours are sufficient to meet Appellant's goals.

The CMH representative further pointed out that the Medicaid Provider Manual requires parents of children with disabilities to provide the same level of care they would provide to their children without disabilities. The CMH representative explained that this meant that public benefits could not be used where it was reasonable to expect the parent would provide care, i.e., if the parent had to purée or cut food into very small pieces to prevent choking, or supervise for safety due to lack of mobility and verbal skills.

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> 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) who 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. (Emphasis added).
>
> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 98*

A review of the Medicaid Provider Manual supports the CMH position that B3 supports and services are not intended to meet all of an individual's needs and that it is reasonable to expect that Appellant's mother would provide care for the period of time proposed by the CMH without use of Medicaid funding.

The Appellant bears the burden of proving by a preponderance of the evidence that the Appellant meets the medical necessity criteria for long-term residential placement, that the 20 hours per week of CLS authorized was inadequate to reasonably achieve the Appellant's CLS goals, and that the 12.5 hours of respite was inadequate to meet the Appellant's mother's goals. The testimony of the Appellant's mother did not meet the burden to establish medical necessity for long-term residential placement above and beyond the 20 CLS hours and 12.5 respite hours determined to be medically necessary by CMH in accordance to the Code of Federal Regulations (CFR). In addition, Appellant's mother failed to establish that Appellant currently meets the criteria for long-term residential placement because there exists a less restrictive, more integrated setting in the community where Appellant can receive services. Appellant should take advantage of out-of-home respite care, work under a behavioral plan, and follow the other recommendations contained in Appellant's Person Centered Plan. If Appellant's behaviors worsen, the situation can always be revisited.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant placement in long-term residential care. In addition, CMH properly determined Appellant's CLS hours at 20 hours per week and Appellant's respite hours at 12.5 hours per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
Docket No. 2012-23911 CMH
Decision and Order

cc: [redacted]

Date Mailed: 2/28/2012

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.