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. 2012-4993 CMH
Case No. 64137955

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 Tuesday, [redacted]. Appellant [redacted] appeared and testified on his own behalf. Appellant's mother, [redacted], appeared and testified on Appellant's behalf.

Attorney [redacted], Assistant Corporation Counsel represented the [redacted] County Community Mental Health (CMH). Dr. [redacted], Ph.D., Manager for Clinical Services, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for continued long-term residential services?

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, born [redacted]. Appellant is enrolled in Medicare (Parts A, B, and D) and in Medicaid, but not in any specialty Medicaid Waivers administered by the Macomb County Community Mental Health (CMH). Appellant also has been adjudicated Social Security benefits. (Exhibit 1, Attachment C, p. 12).

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 currently diagnosed with schizoaffective disorder. (Exhibit 1, Attachment D, p. 29).

4. The Appellant was participating in the Macomb Enhanced Supported Independence Program (ESIP) for which the CMH provides funding for services, primarily community living supports (CLS) staffing. Participants in this program reside in apartments supported by the ESIP. Appellant's community living supports were authorized as "B3" services. (Exhibit 1, Attachment G, pp. 60-62, and Testimony).

5. On [redacted], the CMH sent a notice to the Appellant's mother notifying her that the request for adult residential services was denied effective [redacted] as the Appellant did not meet criteria for the services requested. (Exhibit 1, Attachment A, pp. 6-8).

6. MAHS received Appellant's request for an expedited hearing on [redacted]. (Exhibit 1, Attachment B, p. 10).

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 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

[redacted], a fully licensed psychologist with the CMH testified Appellant was [redacted] years old. He is diagnosed with schizoaffective disorder. [redacted] stated Appellant had been in the ESIP program since 1998. He was residing in an apartment provided by but not paid for by CMH. CMH paid for/provided CLS services and personal services while Appellant was residing in the ESIP program.

[redacted] stated an annual assessment was then done to determine whether Appellant continued to need the more restrictive environment provided by the ESIP residential program. She stated it determined the Appellant could be moved out into the community in a less restrictive setting where he would have his own apartment, but would still be given support services through the CMH, including Case Management Services, outpatient psychiatric services, and therapy sessions with a social worker.

[redacted] indicated a review of Appellant's clinical records showed he was doing well and no longer needed the ESIP level of care. Appellant was still in need of payment

assistance, but had a legal guardian who could assist in this regard. The records showed he was independent in all his activities of daily living, including self care, community living skills, medication administration, and managing his daily life. [redacted] stated Appellant had been medically and psychologically stable over the past year, and there was no indication of any safety or health concerns for the Appellant. [redacted] stated in her professional opinion the ESIP was no longer medical necessary for the Appellant. Furthermore, [redacted] pointed out that [redacted], the psychiatrist who had been treating the Appellant, indicated in the Appellant's annual review that it was his recommendation that the Appellant be transitioned out of the ESIP program.

The *Medicaid Provider Manual, Mental Health/Substance Abuse* section articulates Medicaid policy for Michigan. It provides in part the following with regard to Additional Mental Health Services (B3s):

> **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.

* * *

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, October 1, 2011, pages 104-105.

17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/11]

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 (that exceeds state plan for adults), prompting, reminding, cueing, **(revised 7/1/11)** 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

> the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a 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.
>
> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensorymotor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child. **(added 7/1/11)**
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, October 1, 2011, pages 107-108.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse* section articulates Medicaid policy for Michigan. It states the following with regard to determining medical necessity:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **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/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.

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, October 1, 2011, pages 13-14.

[redacted], Appellant's mother and guardian testified she was not notified by the ESIP program that her son was given a deadline for being out of his apartment provided by the ESIP program. She indicated there was supposed to be a meeting with [redacted], but it got cancelled and he never called to reschedule the meeting. She also attempted to talk with [redacted], but she never returned her call. [redacted] said there was a communication problem with the people running the program.

[redacted] further testified she did not think her son was ready to be on his own. She believes he has many problems that he did not tell [redacted] about. She feels he can't handle things. [redacted] indicated he sometimes thinks there is someone in his room. Also he thinks the TV is talking to him or someone is pinching his leg. [redacted] also criticized [redacted] care of her son. She stated he just handed out a bunch of pills and was not helping David.

Appellant testified he did not believe there was someone in his room. He just likes sleeping with the light on. He also stated he watched the program "Ghost Whisperer" about a person who can see ghosts. Appellant also stated he has wraps on his legs and sometimes gets a "pinchy" feeling in his legs, but when he tells the doctor, the doctor just says he doesn't know what it is from. He also said he hears voices once in a while, but everybody hears voices. Appellant stated he wants to stay in the ESIP program. He also indicated the people running the program never talked to his mother about him getting out of the program.

The relevant policy from the Medicaid Provider Manual establishes that the B3 supports and services are not intended to meet all of the individual's needs and preferences. Also for the determination of medical necessity, support services or treatment must be sufficient in amount, scope and duration to reasonably achieve its/their purpose. Services in excess of this amount are not medically necessary. Finally, using criteria for medical necessity, a PIHP may deny services 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.

The Appellant bears the burden of proving by a preponderance of the evidence that he meets the criteria for the long-term residential services provided by the ESIP program in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden to establish that he met the criteria for such a placement. The CMH established that the Appellant's participation in the ESIP program was no longer medically necessary. While it might be advantageous for the Appellant to remain in the program, B3 services are not intended to meet all of the Appellant's needs. It is appropriate to deny the more restrictive residential services provided by the ESIP program, where a less restrictive setting in the community would still allow the Appellant to obtain CMH services that would meet his individual needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for continued long-term residential services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/6/2011

***** 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.