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. 2012-66018 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 Wednesday, [redacted] Attorney [redacted] appeared on behalf of the Appellant. Appellant's sister [redacted] testified on behalf of the Appellant.

The Community Mental Health Authority for Oakland County (CMH) was represented by Attorney [redacted] [redacted] Community Liv ing Services Assistant Director of Community Supports, and [redacted] Support Coordinator Manager , appeared and testified on behalf of the CMH.

ISSUE

Did the CMH act properly when it deter mined to reduce Appellant's community living supports hours within a three weeks period of time?

FINDINGS OF FACT

The Administrative Law Judge, based upon the com petent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant was a [redacted] Medicaid beneficiary (DOB [redacted] at the time of the hearing. (Exhibit A, pp. 1, 6 and testimony).

2. The Mental Health Aut hority for Oakland County (CMH) is responsible for providing Medicaid-c overed mental health and developmental disab ility services to eligible recipients in its service area.

3. Appellant had been rece iving Medicaid c overed services through CMH, including 38 hours of community li ving support s (CLS) per week. Following the death of A ppellant's mother and primary caregiver in [redacted] Appell ant's CLS hours were incr eased to 158 hours

per week, 22 hours five days per w eek and 24 hours t he other two day s per week, to assist Appellant who was now living alone in the family home. (Exhibit A pp. 2-3 and testimony).

4. Appellant has a diagnos is of Intellectual Disab ility, severity unspecified and Diabetes Uncompl Type II, non-insulin dependent. (Exhibit A, pp. 1, 51 and testimony).

5. On [redacted] following a periodi c review of Appellant's IPOS, dated [redacted] CMH recommended that Appellant's CLS h ours be reduced beginning the week of [redacted], eliminating three 8 hour night shifts per week the first week, an additi onal two 8 hour night shifts were to be eliminated the s econd week, and the third week, t he remaining night shifts were to be eliminated for a to tal reduction of 56 hors per week . (Exhibit A pp. 1-2, 26 and testimony).

6. On [redacted] Appellant was sent an Ade quate Actio n Notice concerning his new/revised PCP/IPOS , due to the proposed reduction in his CLS hours. The notice inf ormed Appellant of his rights to a fair hearing. (Exhibit A pp. 24-25).

7. On [redacted] the Michigan Admi nistrative Hearing System received Appellant's request for hearing.

CONCLUSIONS OF LAW

The Medic al Ass istance Program is establis hed purs uant to Tit le XIX of t he Soc ial Security Act and is im plemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with stat e statute, the Social Welfare Act, the Administrative Code, and the State Plan under Titl e XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Sec urity Act, enacted in 1965, authorizes Federal grants to St ates for medical assist ance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or ch ildren. T he program is jointly financed by the Feder al 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 indi viduals or entities that furnish the services.
>
> [*42 CFR 430.0*]

The State plan is a comp rehensive 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 amount, scope, and duration to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The Code of Federal Regulations, the state Mental Health Code, and Michigan Medicaid policy mandate that appropriate amount, scope and duration is to be determined through the person-centered planning process. It is indisputable that the federal regulations, state law, and policy, require the cooperation of both the Community Mental Health and the Medicaid beneficiary in the person-centered planning process.

The CMH must follow the Department's Medicaid Provider Manual when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, October 1, 2012, Section 2.5* lists the criteria the CMH must apply as follows:

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services and treatment:

- Necessary for screening and asse ssing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and eval uate a mental illness , developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish o r stabiliz e t he symptoms of mental illness, deve lopmental 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 medic ally nece ssary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiar y's family, and/or other
- individuals (e.g., friends, pers onal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health c are professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental ill ness or developmental disabilities , based on person centered planni ng, and for beneficiaries wit h substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmenta l disabilities, or substance
- abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and dur ation of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATM ENT AUT HORIZED 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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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. [pp. 12-14].

The *Medicaid Provider Manual, Mental Health/Substance Abuse, October 1, 2012,* Section 17, articulates Medicaid policy for Michigan, for B3 services including Community Living Supports (CLS).

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. [p. 111].

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).

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. [p. 114].

The testimony of CMH's witnesses along with the documentary evidence admitted during the administrative hearing shows that the Appellant had been receiving Medicaid covered services through CMH, including 38 hours of community living supports (CLS) per week. Following the death of Appellant's mother and primary caregiver in [redacted], Appellant's CLS hours were increased to 158 hours per week, 22 hours five days per week and 24 hours the other two day per week, to assist Appellant who was now living alone in the family home.

Following an IPOS periodic review, the Department proposed to reduce Appellant's nighttime CLS hours, after discussions with Appellant's sister indicated that there had not been any health and safety concerns during the midnight hours. (Exhibit A, p. 26). The CMH witnesses stated the goal of CMH was to reduce the CLS hours down to 16 hours a day, and to eliminate CLS hours during the time the Appellant was asleep. Appellant's CLS hours are being provided on a self determination basis to allow them to be used as needed. Appellant's IPOS periodic review indicates that CLS staff should keep progress notes to identify the level of supports being provided each shift to allow CMH to further assess the Appellant's level of need for further authorizations.

Appellant's position at the hearing was that he did not dispute the reduction in the number of CLS hour. However, Appellant felt the reduction in hours should be accomplished on a more gradual basis. Appellant's sister testified she was a registered nurse. She indicated there were some safety concerns, the Appellant had left the heater light on in the bathroom during the month of August, which she said might cause a fire; and, sometimes when Appellant gets up in the night he will leave the home, one time at 3 a.m. he left the garage door open and was making a racket with the bottles and trash, and another time he went out and left the house open.

Appellant's sister also testified Appellant is diabetic, and he fluctuates between eating too much or not eating at all, which causes problems with his blood sugar. Appellant's sister stated Appellant does not understand the importance of regulating his blood sugar and needs someone there to help him. She preferred a reduction on a trial basis of one night at time without nighttime CLS hours to insure the Appellant would get the assistance he needs before the nighttime CLS hours are eliminated altogether.

The CMH and the undersigned Administrative Law Judge are bound by the Code of Federal Regulations, the state Mental Health Code, and the Medicaid Provider Manual policy. In this case, Appellant did not object to the proposed reduction in hours, only the fact that CMH proposed to eliminate the so-called "nighttime hours" within a three weeks period of time. CMH has offered a reasonable plan of reducing Appellant's CLS hours over a three week period of time, but at the same time requesting that CLS staff keep track of the services provided so that future authorizations will insure that the Appellant receives the care and assistance he needs. If problems arise from the more rapid reduction in services, CMH can adjust the reduction in hours to meet the documented needs.

It should be noted that CMH has proposed eliminating CLS hours during the time which the Appellant is sleeping. Furthermore, it should be noted that the CLS hours are being provided on a self determination basis which allows Appellant to have staff when they are needed, including night time hours if the Appellant chooses to stay up half the night and then sleep during the day. Finally, these Medicaid covered services are B3 services. Medicaid Policy clearly states that B3 supports and services are not intended to meet all of the individual's needs and preferences, as some needs may be better met by community and other natural supports.

Appellant has failed to show by a preponderance of the ev idence that CMH's proposed reduction in services was improper. CMH's proposed reduction in services should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH's pr oposed reduction of the A ppellant's community living supports hours over a three week period of time was proper.

IT IS THEREFORE ORDERED that:

> The CMH decision to reduc e Appellant's community living supports over a three week period of time is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/10/2012

***** 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.