STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],
Appellant

Docket No. 2012-7192 CMH
Case No. 1207883

_____/

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]. [redacted], Appellant's mother appeared and testified, on behalf of the Appellant.

[redacted], Systems Management Specialist and Fair Hearings Officer, for [redacted], [redacted] County's Community Mental Health Authority (CMH), represented the Department. [redacted], Contract Manager for [redacted]; [redacted], Program Administrator for Children's Services at [redacted] Community Services; and, [redacted], Appellant's Supports Coordinator with [redacted] Community Services, appeared as witnesses for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for additional community living supports 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 and is enrolled in Network 180, the Mental Health Authority for [redacted] County. (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. The CMH contracts with [redacted] Community Services ([redacted]) to provide Community Living Supports Services. Appellant

receives supports coordination, respite funding and CLS services through [redacted]. (Exhibit O and testimony).

3. The Appellant is a [redacted] old whose date of birth is July 16, 1998. The Appellant was diagnosed as a child with developmental disabilities, including autism [redacted] disorder, and moderate mental retardation. (Exhibits F & O).

4. The Appellant is an only child and lives with his mother in a single parent household. Appellant's mother works part-time outside of the home. Appellant's mother is his primary caregiver. (Exhibits F & H).

5. On [redacted], an individual plan of service (IPOS) was developed for Appellant and signed by his mother, which authorized 31.5 hours of CLS per week for the Appellant. (Exhibit O).

6. Subsequent to the [redacted] IPOS, the CMH reviewed the way [redacted] was authorizing CLS hours for children and determined that it was authorizing CLS at a level higher than the documented need, as it was failing to apply the Medicaid Manual's requirements that there must be medical necessity for the authorized services. A plan of correction was carried out that required a reassessment for all children receiving more than 15 hours of CLS, including the Appellant.

7. On [redacted], Appellant's current IPOS was developed for Appellant and signed by his mother. The new plan authorizes CMH services from [redacted] through [redacted]. A CLS service profile and worksheet were completed to calculate the number of CLS hours that were medically necessary to satisfy the goals identified in the IPOS. This plan reduced the number of CLS hours to 12 hours per week, down from the previous 31.5 hours per week. Appellant's mother appealed the reduction. (Exhibits G, H &O).

8. Due to problems with the implementation of the correction plan for the authorization of CLS services by [redacted], it was agreed that the CLS hours would be held at 31.5 hours until [redacted]. Appellant's mother then withdrew her appeal of the reduction. (Exhibits A, I & O).

9. On [redacted], after a further reassessment of the Appellant's needs for CLS services. A new CLS service profile and worksheet were completed to calculate the number of CLS hours that were medically necessary to satisfy the goals identified in the IPOS. The CMH reduced the number of CLS hours authorized for the Appellant to 15 hours per week and an addendum to the PCP was issued to reflect this change. (Exhibit C, K & L).

10. On [redacted], an adequate action notice that included rights to a Medicaid fair hearing was completed, which was given to Appellant's mother on [redacted]. (Exhibit C, K & L).

11. The Appellant's request for a hearing was received by this office on [redacted]. (Exhibit A).

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.

The evidence of record shows that the Appellant's person centered plan currently authorizes 15 hours of CLS per week. (Exhibit L). On [redacted], the Appellant's mother-representative appealed, requesting additional CLS hours per week due to the reduction from the 31.5 hours previously authorized.

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

> **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 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.

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.

The CMH witnesses testified the Appellant was currently authorized to receive 15 hours per week of CLS. Additional hours were requested by the mother because Appellant was previously receiving 31.5 hours and she believed her son would not benefit from the reduction in services. The Department denied the request for the additional CLS hours as the documentation reviewed by the CMH did not show that the additional hours were medically necessary to meet the Appellant's needs.

[redacted] testified for the CMH that [redacted] contracted with the CMH to provide CLS services for children enrolled at [redacted]. During a [redacted] audit of [redacted]'s authorization of CLS services, it was found that the authorization of CLS hours was not being clearly documented or explained by the [redacted] staff. It was determined that CLS hours were being authorized in excess of what was medically necessary. Thereafter a correction plan was created which resulted in a reassessment of the number of CLS hours authorized for all children receiving more than 15 hours of

CLS, including the Appellant.

[redacted] testified for the CMH that she was part of the review team that examined the problems with [redacted]'s authorization of CLS services. She was also involved with implementing the correction plan. [redacted] acknowledged that [redacted] had initially authorized 31.5 CLS hours per week for the Appellant's in [redacted]. After the correction plan went into effect, the [redacted] IPOS reduced the amount of CLS hours for the Appellant to 12 hours per week.

[redacted] indicated the reduction was in part due to the fact that school activities were previously figured in to the number of CLS hours authorized in the home and the prior authorization included a number of minutes that went beyond what was medically necessary. Some supports identified earlier were no longer necessary, such as, a behavior plan that included transitioning to other activities, and a communication goal.

[redacted] stated they completed another review of the CLS hours needed for the Appellant on [redacted] and determined that 15 hours per week were medically necessary, i.e., were a sufficient amount to reasonably achieve the goals set forth in the Appellant's IPOS. Accordingly, an addendum was prepared for the IPOS authorizing 15 hours of CLS per week instead of 12 hours per week. [redacted] stated Appellant's mother was in agreement with the IPOS, except that she did not agree with the reduction in CLS hours.

[redacted] testified for the CMH that she was Appellant's Supports Coordinator. [redacted] indicated she reviewed the Appellant's clinical records and completed the CLS Profile and Worksheet in [redacted] to determine the number of CLS hours that were medically necessary for the Appellant. After completing the evaluation tool and taking into consideration the goals set forth in the Appellant's IPOS, she determined that 60 units of CLS or 15 hours of CLS services per week were sufficient to meet the Appellant's needs, to work on the goals set forth in his IPOS.

[redacted] prepared an addendum to the Appellant's [redacted] IPOS to increase the CLS hours from 12 hours per week to 15 hours per week. [redacted] noted that the Appellant had really improved in a lot of areas, one of the biggest being his socialization skills, due to getting out into the community with the CLS Staff and socializing with other people. She was unable to say what would happen to the Appellant after a reduction in the CLS hours goes into effect.

The Appellant's mother [redacted] testified that her son is [redacted] years old, [redacted] tall, and [redacted] lbs. He is approaching puberty and had no male influence in the home. [redacted] stated she now has male CLS workers that can provide the needed male influence in the home. [redacted] indicated it is important to have these CLS workers in the home to help improve Appellant's writing and tracing skills, and to improve his communications skills beyond 2 to 3 word sentences.

[redacted] does not believe that her son will benefit from a reduction in CLS hours from 31.5 hours per week down to 15 hours per week. She believes her son will lose ground with such a reduction. [redacted] argued that she understood the Medicaid guidelines must be met, but she thought a reduction of more than 50% was out of line.

The Appellant bears the burden of proving by a preponderance of the evidence that additional hours of CLS services are medically necessary. The Appellant's mother was given the opportunity to prove why additional CLS hours were necessary. The testimony of the Appellant's mother was not specific enough to establish medical necessity above and beyond the number of respite services and CLS hours the CMH assessed in accordance to the Code of Federal Regulations (CFR).

The CMH must authorize CLS services in accordance to the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when authorizing 15 hours per week of CLS for the Appellant. The Appellant failed to prove by a preponderance of the evidence that additional hours of CLS services per week are medically necessary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the request for additional hours per week of CLS services beyond the 15 hours per week authorized for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

William D Bond

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

cc: [redacted]

Date Mailed: 12/5/2011

***** 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.