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. 2012-8397 CMH

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.

SUMMARY

On [REDACTED], the Appellant, through his attorney [REDACTED], filed a request for a Medicaid fair hearing. The Appellant contested the CMH's termination of [REDACTED] hours per week that had been authorized for Appellant for personal care assistance, pending a decision on Appellant's application for Adult Home Help through Department of Human Services (DHS). An in person hearing was scheduled for [REDACTED], but adjourned at the request of the Appellant's Attorney due to a conflict. The matter was rescheduled for [REDACTED] but was adjourned at the request of the Respondent's Attorney [REDACTED] due to a conflict in his schedule. The matter was rescheduled for [REDACTED] and was again adjourned at the request of the Appellant's Attorney due to another conflict in her schedule. The matter was rescheduled for an in person hearing to be held on [REDACTED], at the [REDACTED] County [REDACTED]. Due to unforeseen circumstances the location of the hearing was switched on the morning of the hearing to a conference room at [REDACTED] also in [REDACTED]

Prior to the start of the hearing a courier arrived from [REDACTED] office and presented the Administrative Law Judge and Respondent's Attorney with a cover letter dated [REDACTED] and an attached document labeled Brief in Support of Appeal dated [REDACTED] The cover letter indicated the brief was in lieu of appearance. The letter alleges that [REDACTED] was advised by an unnamed person from the CMH that the hearing scheduled for [REDACTED] had to be adjourned and, therefore, she made another unspecified commitment and could not attend the hearing. At no time did [REDACTED] receive an official notification by MAHS that the matter was to be adjourned. Further, [REDACTED] did not obtain leave of this Administrative Law Judge to file the Brief in lieu of the Appellant's appearance. Accordingly, the Appellant's Brief was retained as evidence of the Appellant's nonappearance, but will not be considered for purposes of a decision in this matter. Accordingly, the hearing proceeded in the absence of the

Appellant and/or his Attorney under the following provisions contained in the Administrative Procedures Act, MCL 24.272(1) and MCL 24.278(2).

The Community Mental Health Authority for was represented by Attorney . Supports Coordinator Supervisor,) appeared as a witnesses for the CMH.

ISSUE

> Did the CMH properly terminate Appellant's additional community living supports hours of hour per week put in place for Appellant's personal care assistance, once DHS approved Adult Home Help hours for Appellant's personal care assistance?

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 County Community Mental Health (CMH).

2. The Appellant is a year-old male Appellant qualifies for services provided through the CMH as a person with developmental disability. Appellant is currently receiving hours of Community Living Supports ( ) per week, flexible quarterly hours per week of Respite Care, flexible quarterly; Respite Overnight per annum, Supports Coordination, and Nursing Services. In addition Appellant is also receiving hours per week of Adult Home Help) through Department of Human Services (DHS) to provide for Appellant's personal care assistance. (Exhibits 1-2 and testimony).

3. 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.

4. On , Appellant's services were reviewed and miles of CLS Transportation and an additional 14 hours of CLS per week were added. The CLS hours were added for Appellant's person care assistance, pending possible approval by DHS of hours to cover this specific need for personal care services. (Exhibits 1-2 and testimony).

5. On , the CMH was advised that DHS had approved hours per week of to cover Appellant's personal care assistance, retroactive to . (Exhibits 1-2 and testimony).

6. On , Appellant was sent an Advance Action notice that the additional 14 CLS hours for personal care assistance would be terminated effective , as the personal care assistance would now be provided through . The letter informed Appellant of his rights to a fair hearing. (Exhibits 1-2 and testimony).

7. On , the Michigan Administrative Hearing System received Appellant's request for hearing.

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 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 and the Medicaid beneficiary are bound by the Code of Federal Regulations, the state Mental Health Code, and state Medicaid policy. As such, both parties must cooperate in the development of a person-centered plan before Medicaid services can be authorized.

> MCL 330.1712 Individualized written plan of services.
>
> (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall

address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or his individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

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, Section 2.5* lists the criteria the CMH must apply. The Medicaid Provider Manual sets out the eligibility requirements as:

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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, April 1, 2012, page 13.

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.

The Medicaid Provider Manual specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

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.

Community Inclusion and Participation

The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation) (emphasis added by A LJ)

Independence "Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to

bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

The CMH determined that the Appellant did meet medical necessity criteria to have an authorization of 47.5 hours of Community Living Supports (CLS) authorized each week. However, in January of 2011 an additional 14 hours of CLS were authorized pending authorization of AHH through DHS. Following the authorization of AHH by DHS the additional CLS hours for this purpose were terminated. Appellant has appealed from this termination of the additional 14 hours that were only put in place pending authorization of the AHH by DHS.

The *Medicaid Provider Manual, Mental Health/Substance Abuse S*ection articulates Medicaid policy for Michigan, specifically including CLS.

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, April 1, 2010, Page 100.

The testimony of the CMH's witness along with the documentary evidence admitted during the administrative hearing established that the CLS authorization of [redacted] hours was adequate to meet the Appellant's needs at this time. The CLS hours are flexible quarterly and a review of service records shows that to date, the Appellant has never run out of [redacted] hours. Furthermore, it was shown that Appellant's mother was in agreement when the additional [redacted] hours of [redacted] were approved in [redacted] pending the authorization of [redacted] through DHS.

The Medicaid policy makes it clear that additional [redacted] hours may be authorized pending authorization of [redacted] hour, but that [redacted] hours cannot 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). There is insufficient evidence of record to find the authorization of [redacted] is inadequate to meet the Appellant's needs, following the termination of the [redacted] hours authorized only until the [redacted] hours were put in place by DHS. 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. Based on the credible, preponderant evidence in this record, it was proper for the CMH to terminate Appellant's additional [redacted] hours that were only put in place until the [redacted] hours could be approved.

The undersigned would further note that Appellant previously appealed the adequacy of

the hours of per week in Docket No. 2011-12275 CMH, and the affirmance by Administrative Law Judge Jennifer Isiogu is currently being reviewed in the Circuit Court. (See Exhibit 3).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the termination of the Appellant's additional hours per week of CLS services was proper as Medicaid policy clearly indicates that it was proper for such services to be put in place only until the hours were approved by DHS.

IT IS THEREFORE ORDERED that:

> The CMH decision to terminate the additional 14 hours per week of CLS services put in place pending the approval of the AHH by DHS is AFFIRMED.

William D Bond

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

cc:

Date Mailed: ___4-25-12____________________

***** 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.