

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 2013-19786 CMH
Case No. [REDACTED]

[REDACTED],

Appellant

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [REDACTED]. Appellant's father/guardian Steven Wujcik appeared on behalf of the Appellant. Appellant's mother, Jeanette Breznau appeared as a witness for the Appellant.

[REDACTED], corporate counsel for [REDACTED] County Community Mental Health ([REDACTED]), represented the Department of Community Health (CMH). [REDACTED], Fair Hearing Officer for [REDACTED] was present. [REDACTED], MA, [REDACTED] Coordinator, appeared as a witness for CMH.

ISSUE

Did CMH properly deny the Appellant's request for an additional six hours per day of Community Living Supports (CLS)?

FINDINGS OF FACT

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

1. Appellant was a [REDACTED] year old Medicaid beneficiary (DOB [REDACTED]) at the time of the hearing. (Exhibit A, pp. 3, 10 and testimony).
2. [REDACTED] Community Mental Health & Substance Abuse Services (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area. CMH has a County Financial Responsibility Agreement with [REDACTED] Community Health Organization to provide Medicaid covered services for the Appellant. (Exhibit A, Attachment to Hearing Summary, p. 1 and testimony).

3. Appellant receives Medicaid covered services on a self determination basis as a person with a developmental disability, including 18 hours per day of community living supports (CLS). In addition, Appellant's Individual Plan of Service (IPOS), authorized Supports Coordination as needed including at least one annual meeting and monthly home visits (60 minutes/4 units per month), monthly nursing visits by an RN to monitor Appellant's condition, and Occupational Therapy. In addition Appellant receives 6.2 hours of Home Help Services through the Department of Human Services. (Exhibit A, pp. 11-13 and testimony).
4. The Appellant is diagnosed with Autism, Impulse-Control Disorder NOS, Tic Disorder NOS, Bipolar Disorder NOS, Anxiety Disorder NOS and severe mental retardation. He is visually impaired and has poor communication skills. (Exhibit A, p. 6).
5. The Appellant is eligible for school through ██████████ ISD; however, he is not registered at this time. (Exhibit A, p. 13).
6. The Appellant's guardians/parents requested an additional six CLS hours per day, which was denied by CMH on ██████████. CMH sent Appellant's guardians/parents an Action Notice stating that Appellant's eligibility for these services was reviewed by ██████████, CMH's Senior Executive for Services for Individuals with Developmental Disabilities, and based on his reported needs, it was determined that Appellant did not meet medical necessity for an increase in CLS hours at that time. CMH determined that the current authorization of 18 hours per day of CLS was sufficient in amount, scope and duration to reasonably achieve the goals in Appellant's person centered plan. (Exhibit A, pp. 1-2).
7. On ██████████, MAHS received the Appellant's Request for Hearing. The Appellant's guardians/parents stated in their request for hearing that they believed Appellant now needs more than 24 hour care, and they were asking for six more CLS hours, for a total of 24 hours per day. (Exhibit A, p.3).

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) Medicaid Managed Specialty Services waiver. Kalamazoo County Community Mental Health (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

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.

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/Substance Abuse, April 1, 2013, pp. 12-
14.

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).

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.

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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

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 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

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- 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.

Medicaid Provider Manual, Mental Health/Substance Abuse,
April 1, 2013, pp. 110-114.

In this case, it is undisputed that CLS services are medically necessary for the Appellant. He is authorized to receive 18 CLS hours per day. In addition, Appellant is authorized to receive Supports Coordination as needed including at least one annual meeting and monthly home visits (60 minutes/4 units per month), monthly nursing visits by an RN to monitor Appellant's condition, Occupational Therapy, and he receives 6.2 hours of Home Help Services through the Department of Human Services. Appellant is also eligible to receive school services through the ██████████ ISD, but his parents/guardians are not currently utilizing these services. Instead, they have requested an additional six hours per day of CLS services. At the hearing they indicated they are requesting the additional CLS hours to allow for some two on one staffing.

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██████████, MA, CMH ██████████ Coordinator stated he has a Master's Degree in Counseling Psychology. He stated he is familiar with Appellant's case and has been coordinating and monitoring his services since ██████████. ██████████ stated he has annual meetings as part of the appellant's supports team and reviews Appellant's annual plans and assessments to determine his needs and the services necessary to meet his individual needs. He stated Appellant is currently authorized by CMH to receive 18 hours CLS per day, supports coordination services, nursing services, occupational therapy services, and through DHS he receives a little over 6 hours per day of home help services.

██████████ stated he reviews the information provided by Washtenaw CMH on an on going basis including the Appellant's progress reports to determine his need for services. ██████████ stated based upon the Appellant's current situation, his professional opinion was that the Appellant's current services were the same that he has had in place for the past couple of years, and the amount of services is adequate to meet his current needs. He stated medical necessity is met for his current level of services as they benefit the Appellant by providing treatment for his current symptoms and his developmental disability in order to maintain his current level of independent living. ██████████ stated the Appellant's current circumstances simply do not support medical necessity for two on one staffing. He further stated the on going documentation concerning the Appellant's condition has shown that his level of self injurious behavior had remained fairly constant over the past couple of years. ██████████ stated the information provided to him did not show a need for additional CLS staffing.

Furthermore, at the time the Appellant's parents sought the additional six CLS hours per day, Appellant's eligibility for the services was reviewed by ██████████, CMH's Senior Executive for Services for Individuals with Developmental Disabilities. Based on the appellant's reported needs, it was determined that Appellant did not meet medical necessity for an increase in CLS hours at that time. CMH determined that the current authorization of 18 hours per day of CLS was sufficient in amount, scope and duration to reasonably achieve the goals in Appellant's person centered plan.

Appellant's mother testified they had requested two on one staffing in their meetings with ██████████. She stated the Appellant weighs 136 pounds and it is impossible for one person to change his diapers. Appellant's mother stated she told ██████████ that it was too hard for her to do any more, but as the Appellant's mother she continues to do it.

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 parents were given the opportunity to prove why additional CLS hours were necessary. The testimony of the Appellant's mother did not establish medical necessity above and beyond the number of CLS hours the CMH assessed in accordance with the Code of Federal Regulations (CFR).

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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 it authorized 18 hours per week of CLS for the Appellant, in addition to the other Medicaid services the Appellant has been authorized to receive. 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, finds that the authorization of 18 hours per day of Community Living Supports are sufficient in amount, scope and duration to reasonably achieve the goals as stated in the person centered plan.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

William D Bond

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

cc:



Date Mailed 4/12/2013

***** 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.