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) 334-4147

IN THE MATTER OF:

[redacted]

Docket No. 14-011177 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], Appellant's legal guardian, appeared and testified on Appellant's behalf. [redacted], Caregiver and [redacted], Supports Coordinator, appeared as witnesses for Appellant.

[redacted], Assistant Corporation Counsel, represented [redacted] County Community Mental Health Authority (CMH or Department). [redacted], [redacted] Director, appeared as a witness for the CMH.

ISSUE

Did the CMH properly reduce Appellant's Community Living Supports (CLS) hours from 40 to 30 hours per week?

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 is a [redacted] year old Medicaid beneficiary, born [redacted], receiving services through [redacted] County Community Mental Health (CMH). (Exhibit A, p 13; Testimony)

1. 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. (Testimony)

2. Appellant is diagnosed with Asperger's Syndrome, mild mental retardation, obesity, shortness of breath and wheezing. Appellant struggles with water retention and some mobility due to shortness of breath and his weight. (Exhibit A, pp 20, 30; Testimony)

3. Appellant lives alone and has limited natural supports. Appellant's mother and siblings have passed away. Appellant's CLS worker is a great support to him and his neighbors check on him. Appellant's cousin is his court appointed guardian and his representative payee is set up through [redacted]. (Exhibit A, pp 13, 20; Testimony)

4. Appellant has been receiving support coordination services through CMH for the past two years. Appellant currently receives CLS services through [redacted]. CLS staff and Appellant's guardian report that with CLS guidance and training, Appellant has made progress towards his goals. (Exhibit A; p 21; Testimony)

5. The goals in Appellant's Person Centered Plan (PCP) that pertain to CLS services include: (1) developing a daily schedule at least once per week; (2) training and guidance in time-management and understanding time structure to make choices for his future; (3) training in locating community resources, including recreational centers, libraries, parks, etc. Providing assistance with purposeful things to do at home and in the community; (4) developing a budget and receiving assistance with money management; (5) training and guidance with preparing meals and cooking, as well as housekeeping. (Exhibit A, pp 34-39; Testimony)

6. In [redacted], a request was made on Appellant's behalf for a continuation of the 40 hours of CLS per week that he had received previously. After reviewing Appellant's Annual Assessment, Person Centered Plan, and electronic medical records, CMH approved Appellant for 30 hours of CLS per week. (Exhibit A, pp 12-29; Testimony)

7. On [redacted], Appellant was notified of the reduction in his CLS hours from 40 to 30 hours per week. The reason for the action was, "Services authorized are sufficient in amount, scope, and duration to reasonably meet the goals of promoting community inclusion, participation, independence and productivity." (Exhibit A, pp 8-9)

8. Appellant's request for a hearing was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit 1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR).

It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and

1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

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 *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. It states, in relevant part:

> **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. <u>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,</u>

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.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, (that exceeds state plan for adults) prompting, reminding, cueing, 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.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
April 1, 2014, pp 112, 114-115.

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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- 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;

- 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;

- that are 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 Chapter
April 1, 2014, pp 12-14

CMH's [redacted] Director testified that one of the functions of the [redacted] is to determine eligibility and level of care for services. CMH's [redacted] Director indicated that Appellant is [redacted] years old and diagnosed with Asperger's syndrome and mild mental retardation. CMH's [redacted] Director testified that CMH has served Appellant since [redacted] and that Appellant has been receiving supports coordination services and CLS services. CMH's [redacted] Director testified that CLS services are B3 services and are not intended to meet all of a beneficiary's needs. CMH's [redacted] Director also indicated that the authorization of CLS must meet medical necessity criteria. CMH's [redacted] Director reviewed Appellant's goals found in his PCP and determined that those goals could be met with 30 CLS hours per week. CMH's [redacted] Director also indicated that some of Appellant's goals could also be met through the Home Help Program administered by the Department of Human Services and that those services should be accessed before CLS per policy.

Appellant's guardian testified that they have been working through the process of getting services in place for Appellant and so far those services have worked very well. Appellant's guardian indicated that Appellant's CLS hours were lower initially, but since they increased to 40 hours per week, Appellant has been doing very well. Appellant's guardian indicated that Appellant is a hard nut to crack, but that Appellant's supports coordinator and caregiver have done a great job reaching him. Appellant's guardian testified that one of Appellant's issues is his obesity, which has led to eating problems. Appellant's guardian indicated however that his caregiver has worked with him on rationing his meals and he has started to lose some weight. Appellant's guardian testified that the 40 CLS hours per week have worked very well for Appellant and he does not want to see Appellant regress.

Appellant's caregiver testified that she would submit a case summary which outlines the steps she has taken working with Appellant over the past 2 years. Appellant's caregiver indicated that she has worked well with him, but that Appellant shows signs of depression and is not self-motivated, so her daily interaction is important. Appellant's caregiver testified that she has been working with Appellant on his ADL's and he has made some progress in those areas. Appellant's caregiver indicated that the 40 CLS hours per week works best for Appellant because it allows her to stretch the hours out over 7 days per week so that Appellant knows that someone will be coming to assist him every day.

Appellant's supports coordinator testified that Appellant was doing very well with 40 CLS hours per week and that he had become more motivated and talkative, but had regressed some since his hours were reduced. Appellant's supports coordinator indicated that he has noticed too that Appellant suffers from depression. Appellant's supports coordinator opined that Appellant just did best with 40 CLS hours per week, so if the problem is not broke, don't fix it.

Appellant bears the burden of proving by a preponderance of the evidence that the additional 10 hours of CLS per week are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing 30 hours per week of CLS for Appellant. Appellant failed to prove by a preponderance of the evidence that an additional 10 hours per week of CLS was medically necessary.

As indicated above, B3 services are not intended to meet all of a consumer's needs and preferences. Furthermore, it appears that Appellant has not attempted to access Home Help Services (HHS) through the Department of Human Services and it is clear that many of the goals in Appellant's PCP could be helped along with the HHS program. Policy also dictates that services such as HHS should be accessed prior to CLS services. Based on the evidence presented, the current amount of CLS authorized is sufficient in amount, scope and duration to reasonably meet the goals listed in Appellant's PCP.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's CLS hours from 40 to 30 per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

RJM/[redacted]

Date Signed: [redacted]

Date Mailed: [redacted]

***** 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.