STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 14-010562 CMH

[redacted] [redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted], Appellant's father and power of attorney, appeared and testified on Appellant's behalf. [redacted], Appellant's independent supports coordinator, also testified on Appellant's behalf. [redacted], Manager of Due Process, represented Respondent [redacted] [redacted] Assistant Director of Community Supports, and [redacted], Self-Determination Coordinator, from Community Living Services of [redacted] (CLS-[redacted]) testified as witnesses for Respondent.

ISSUE

Did OCCMHA properly deny Appellant's request for additional 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. [redacted] is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services.

2. In turn, [redacted] contracts with service providers such as CLS-[redacted].

3. Appellant is a [redacted] year-old Medicaid beneficiary who has been diagnosed with Asperger's Syndrome; Pervasive Developmental Disorder, not otherwise specified; Obsessive-Compulsive Disorder; and Bipolar Disorder. (Respondent's Exhibit A, pages 27, 30).

4. Due to his conditions, Appellant is never left alone in his home, which he shares with his father, for more than [redacted] minutes at a time and he is monitored at all times while out in the community. (Respondent's Exhibit A, pages 22-23; Testimony of Appellant's representative).

5. Appellant also has manic episodes and a tendency to wake up in the middle of the night, which causes poor sleep, and he needs verbal prompting and soothing to get back to sleep. (Respondent's Exhibit A, page 23).

6. Appellant has been receiving services through [redacted] and CLS[redacted], including supports coordination, medication reviews, fiscal intermediary services, non-emergency transportation, respite care services, and CLS. (Respondent's Exhibit A, page 21; Testimony of Appellant's representative; Testimony of [redacted]).

7. Specifically, Appellant has been approved for [redacted] hours per month of respite care services and [redacted] hours per month of CLS through CLS-[redacted] self-determination program. (Respondent's Exhibit A, pages 21, 30; Testimony of Appellant's representative; Testimony of [redacted]

8. On [redacted], an Individual Plan of Service (IPOS) meeting was held with respect to Appellant's services for the upcoming year. (Respondent's Exhibit A, page 10).

9. As part of the development of the IPOS, Appellant and his representative requested that an additional [redacted] hours per month of CLS be approved. (Petitioner's Exhibit 2, page 1; Respondent's Exhibit A, page 30).

10. In making the request, Appellant's representative stated that he can now only provide [redacted] hours per week of natural/informal supports and that the additional CLS would replace hours of supports that he was previously providing. (Petitioner's Exhibit 2, page 1; Testimony of Appellant's representative; Testimony of [redacted]).

11. [redacted] reviewed the request and forwarded a recommendation to her supervisor that the request be denied on the basis that the additional CLS hours were not medically necessary to meet the goals and objectives outlined in Appellant's plan. (Testimony of [redacted].

12. Lindstrom then reviewed the request and determined that it should be denied pursuant to CLS-[redacted] policy that it will not provide more than [redacted] hours of support services per day to a beneficiary in a single living situation unless there is a medical necessity for the individual to live alone with one-to-one support staff. (Testimony of [redacted]).

13. On [redacted] CLS-[redacted] sent Appellant written notice that the request for additional CLS was denied. (Respondent's Exhibit A, pages 6-7).

14. Regarding the reason for the denial, the notice provided:

> Your request has been denied. Community Living Services of [redacted] and [redacted] have made a utilization management decision to provide no more than [redacted] hours support services per day for single living situations unless there is a documented clinical rationale (medical necessity) for an individual to live alone with one to one support staff.

Respondent's Exhibit A, page 6

15. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Petitioner's Exhibit 1, page 1).

16. On [redacted], MAHS sent out notice of a telephone hearing scheduled for [redacted].

17. On [redacted], Appellant's representative requested that the hearing be held in-person.

18. On [redacted], the matter was rescheduled as an in-person hearing on [redacted].

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*

Additionally, 42 CFR 430.10 states:

> 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 also 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…
>
> *42 USC 1396n(b)*

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.

Among the services that can be provided pursuant to that waiver are CLS and respite care services. With respect to those services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/14]**
>
> **NOTE:** This service is a State Plan EPSDT service when delivered to children birth-21 years. **(text added 7/1/14)**
>
> 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 services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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, sensory-motor, 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. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

17.3.I RESPITE CARE SERVICES [RE-NUMBERED & CHANGES MADE 7/1/14]

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)

- Home of a friend or relative chosen by the beneficiary and members of the planning team

- Licensed camp

- In community (social/recreational) settings with a respite worker trained, if needed, by the family

- Licensed family child care home **(text added 7/1/14)**

Respite care may not be provided in:

- day program settings
- ICF/IIDs **(revised 7/1/14)**, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 130-132

However, while both CLS and respite care are covered services, Medicaid beneficiaries are still only entitled to medically necessary services as the waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230. Regarding medical necessity, the applicable version of the MPM states:

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.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 12-14

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS and respite care services:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s) [CHANGE MADE 7/1/14]**
>
> 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. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment. **(text added 7/1/14)**
>
> **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.

* * *

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.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 117-118

Here, it is undisputed that Appellant requires both respite care service and CLS, and he has continually been authorized for such services. Instead, it is the amount of hours to be authorized that is at issue, with [redacted] only willing to approve [redacted] hours per month of respite care services and [redacted] hours per month of CLS while Appellant's representative is requesting an additional 169 hours per month of CLS.

Appellant bears the ultimate burden of proving by a preponderance of the evidence that [redacted] erred in denying the request for additional CLS. However, Respondent also bears the initial burden of going forward with sufficient evidence to show that its action is correct and in accordance with law and policy.

For the reasons discussed below, the undersigned Administrative Law Judge finds that Respondent has failed to meet that initial burden of proof in this case and that the [redacted]s decision regarding the denial of additional CLS must therefore be reversed.

As provided in the notice of denial, Appellant's request for additional CLS was denied pursuant to the utilization management decision of CLS-[redacted] and [redacted] to provide a maximum of [redacted] hours of support services per day to beneficiaries living in a single living situation unless there is a documented clinical rationale for the individual to live alone with one-to-one support staff.

In support of its decision to set a limit of [redacted] hours per day for services in this case, [redacted] relies solely on the language in the above policy providing that decisions

regarding the authorization of B3 services, such as CLS and respite, "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." MPM, July 1, 2014 version, Mental Health/Substance Abuse Chapter, page 118.

However, while the MPM contains the language relied upon by Respondent, Respondent failed to offer any evidence regarding its capacity to reasonably and equitably serve other Medicaid beneficiaries or in support of its utilization management decision to limit services to [redacted] hours per day in all cases to where a beneficiary lives in a single living situation unless there is a medical necessity for that living situation.

Moreover, the undersigned Administrative Law Judge finds the above policy language insufficient on its own to support an arbitrary limit on services in this case that does not take into account Appellant's specific circumstances, including the services identified during person-centered planning; the medical necessity for those services; what the least restrictive environment is; and Appellant's individual goals. All of those other factors are also identified in the above policy and there is no suggestion that they were taken into account here.

Respondent can take its capacity to reasonably and equitably serve others into account when authorizing CLS, but it failed to demonstrate that it did so in this case or that it considered other factors identified by policy. Accordingly, Respondent failed to meet its initial burden of going forward with sufficient evidence to show that its action is correct and in accordance with law and policy, and its decision to deny Appellant's request must therefore be reversed.

Nevertheless, it is not clear from the record that that Appellant's request for additional CLS should be granted or that, if additional CLS is approved, that Appellant's respite care hours should not be decreased at the same time. For example, Appellant's current respite care is based on the fact that his father is providing significant informal supports and, consequently, requires relief from the daily stress and care demands that arise from providing that unpaid care. If, however, the vast majority of that informal support is replaced by CLS, as requested by Appellant and his father, Appellant's father should require considerably less relief from the daily stress and demands of caring for Appellant and the approved respite care should be reduced.

Accordingly, while the basis for the denial was improper and Respondent's decision must be reversed, the undersigned Administrative Law Judge will not order that Appellant's request be granted and, instead, will only order that the request be reassessed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] improperly denied Appellant's request for additional CLS.

IT IS THEREFORE ORDERED that:

Respondent's decision is **REVERSED** and it must initiate a reassessment of Appellant's request for additional CLS.

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [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.