**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.** 2014-33798 CMH

[redacted] [redacted] [redacted]

Appellant

_____/

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon a request for hearing filed on behalf of Appellant.

After due notice, a hearing was held on [redacted] a Disability Resource Specialist at the [redacted], appeared and testified on Appellant's behalf. [redacted], Appellant's mother, also testified as a witness for Appellant. Appellant and his nephew were present during the hearing, but did not participate. [redacted] Manager of Due Process, represented Respondent [redacted] County Community Mental Health (CMH). [redacted] Assistant Director of Community Supports, and [redacted] Self Determination Coordinator, from Community Living Services, Inc. (CLS) testified as witnesses for Respondent.

## ISSUE

Did the CMH properly deny Appellant's request for installation of hand rails?

## 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 CMH is under contract with the Michigan Department of Community Health (MDCH) to provide specified Medicaid covered services to people who reside in the CMH's service area.

2. In turn, the CMH contracts with agencies/service providers such as CLS to authorize and provide Medicaid covered services.

3. Appellant is a[redacted] year-old Medicaid beneficiary who has been diagnosed with a cognitive disorder, NOS, and primary cerebellar degeneration. (Respondent's Exhibit A, page 16).

4. Appellant has been receiving services through the CMH and CLS, including supports coordination, Community Living Supports, and respite care services. (Respondent's Exhibit A, pages 6-8).

5. On [redacted] an Individual Plan of Service (IPOS) meeting was held with respect to Appellant's IPOS for the upcoming year and specific goals were identified relating to increasing leg strength; participating in community activities; support in school; physical assistance with Activities of Daily Living; a healthy home environment; range of motion; and self-expression. (Respondent's Exhibit A, pages 1-5).

6. It was also noted during that meeting that Appellant is never left home alone and that he is generally dependent on others for mobility in the community, fire safety, and tornado safety. (Respondent's Exhibit A, pages 9, 11).

7. In [redacted] at Appellant's mother's request, her landlord placed a ramp at the back door of Appellant's home. (Testimony of [redacted]).

8. Subsequently, Appellant's mother requested that CLS install hand rails for that ramp. (Testimony of [redacted]).

9. On [redacted], CLS sent Appellant written notice that the request for environmental modifications was denied on the basis that the hand rails were not medically necessary. (Respondent's Exhibit C, pages 1-2).

10. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed this case. (Petitioner's Exhibit 1, pages 1-2).

## 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*

Moreover, 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.

Environmental modifications are among the services that can be provided by the CMH and CLS pursuant to that waiver and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **17.3.D. ENVIRONMENTAL MODIFICATIONS**
>
> Physical adaptations to the beneficiary's own home or apartment and/or work place. *There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options*, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. *All modifications must be prescribed by a physician*. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.
>
> Coverage includes:
>
> - The installation of ramps and grab-bars.
> - Widening of doorways.
> - Modification of bathroom facilities.
> - Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
> - Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.

- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.

- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.

- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.

- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

*Coverage excludes:*

- *Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.*

- *Adaptations or improvements to the home that are of general utility* or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.

- Cost for construction of a new home or new construction (e.g., additions) in an existing home.

- Environmental modifications costs for improvements exclusively required to meet local building codes.

- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, or the Americans with Disabilities Act; or are the responsibilities of the Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

*Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing.* A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

> If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.
>
> *MPM, January 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 116-118*
> *(Emphasis added)*

However, while environmental modifications are a covered service, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive 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, January 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 environmental modifications:

> **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.*
>
> * * *

**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, January 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 111-112*
> *(Emphasis added)*

The CMH and CLS denied Appellant's request for hand rails in this case pursuant to the above policy. Specifically, as stated in the notice of denial and testified to by the Respondent's witness during the hearing, it found that the requested hand rails were not medically necessary because the current method of using the ramp, having someone assist Appellant, is the most appropriate and cost-effective service method of meeting Appellant's needs, especially where there are no goals identified in his IPOS relating to any need for hand rails and Appellant would still need someone assisting him even if hand rails were installed.

Appellant and his representative bear the burden of proving by the preponderance of the evidence that the CMH and CLS erred in denying the request for installation of hand rails.

Here, Appellant and his representative have failed to meet that burden of proof. While hand rails may be beneficial in allowing Appellant to propel himself on the ramp, they are not medically necessary as his current method of using the ramp is meeting his needs.

It is also undisputed that, even if Appellant himself used the hand rails, he would still need to be supervised and it is clearly more cost-effective to simply have that person continue to assist him without installing the hand rails. "There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options", *see* MPM, January 1, 2014 version, Mental Health/Substance Abuse Chapter, page 116, and there has been no such showing in this case.

Moreover, as discussed above, B3 support and services such as environmental modifications must be identified during the person-center planning and be expected to help achieve the goals listed in the beneficiary's plan of service or outcomes that are typical in his community. In this case, however, there were no specific goals identified in Appellant's IPOS relating to a need for hand rails. Similarly, to the extent Appellant's representative and witness assert that the hand rails would generally promote

community inclusion and independence, those assertions are also insufficient given that neither Appellant's community inclusion or independence would be increased by the presence of hand rails. He is already able to access the community with assistance and he would still require the same one-on-one assistance even if the hand rails were installed.

The expense of installing the hand rails is not dispositive in this case, but the above policy does specifically provide that the environmental modifications must be the most cost-effective alternative to meet Appellant's needs and that decisions regarding the authorization of B3 services must take into account Respondent's capacity to assist others. Here, given the less-costly alternative that is already being used to meet Appellant's needs and the minimal effect the hand rails would have on Appellant goals, the undersigned Administrative Law Judge finds that Appellant's burden of proof has not been met and the decision to deny his request must be affirmed.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH and MORC properly denied Appellant's request for installation of hand rails.

**IT IS THEREFORE ORDERED** that:

The Respondent's decision is **AFFIRMED**.

Steven Kibit

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.