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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2014-35920 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], mother, appeared and testified on Appellant's behalf.

[redacted], Fair Hearings Officer, represented [redacted], the mental health authority for [redacted] (CMH or [redacted]). [redacted], Contract Manager; [redacted], Children's Services Administrator, [redacted]; and [redacted], Supports Coordinator, [redacted], appeared as witnesses for the Department.

ISSUE

Did the CMH properly calculate Appellant's 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 is a [redacted] year old Medicaid beneficiary, born [redacted], who is diagnosed with Autism Spectrum Disorder, Moderate Cognitive Impairment, Allergies (tree nuts and latex), and has problems related to his social environment. (Exhibit D, pp 1-3; Testimony).

2. [redacted] is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area. [redacted] (SCS) is a provider on the [redacted] provider panel and provides Appellant's CLS services. (Exhibit D; Testimony)

3. Appellant lives in an apartment with his mother in [redacted], Michigan.

Appellant's mother has no other immediate family living in the State. Appellant does see his father every other weekend and sometimes longer. (Exhibit D, p 2; Testimony).

4. Appellant's natural supports consist of his parents, who are divorced. (Exhibit D, p 2; Testimony)

5. Appellant currently attends [redacted] and will be entering High School in the fall of [redacted]. (Exhibit D, p 4; Testimony)

6. In [redacted], Appellant's Supports Coordinator at SCS completed a Social Assessment in preparation for service planning for the upcoming year. After reviewing Appellant's needs, the Supports Coordinator recommended that Appellant continue to receive CLS services to increase independence, community inclusion, and healthy habits. (Exhibit D, pp 1-7; Testimony)

7. On [redacted], Appellant's Supports Coordinator completed a CLS Services Worksheet and a CLS Service Profile in order to determine how many 15 minute units of CLS Appellant would need each week to meet the goals in his Individual Plan of Service (IPOS). Through this process, Appellant's Supports Coordinator determined that 29 15-minute units of CLS per week were medically necessary for Appellant and would meet his needs. (Exhibit E, pp 1-4; Exhibit F; Testimony)

8. Based on the Supports Coordinator's recommendations, [redacted] authorized 29 15-minute CLS units per week for Appellant for the period of [redacted] through [redacted]. This amount of CLS was lower than in the previous period because Appellant had made substantial progress over the past few years. (Exhibit H, p 5; Testimony)

9. On [redacted], Appellant's mother filed a local appeal challenging the reduction in CLS hours. (Exhibit C; Testimony)

10. The local appeal was reviewed by the Director of Clinical Services at SCS, who upheld the determination that 29 15-minute units of CLS were medically necessary and sufficient to meet Appellant's needs. (Exhibits C, pp 2-4; Testimony)

11. On [redacted], Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1)

12. After being notified of the request for hearing, [redacted]'s Contract Manager reviewed Appellant's clinical records and concurred with the decision reached by SCS. (Testimony)

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.
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> *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. BABHA 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 *Medicaid Provider Manual (MPM), Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan.

The MPM states with regard to medical necessity:

> **2.5 MEDICAL NECESSITY CRITERIA**
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> 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 and Substance Abuse Section,
April 1, 2014, pp 12-14.

The MPM states with regard to community living supports:

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:

  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator **must** request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and nonmedical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

> CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. (Underline emphasis added by ALJ).
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> *Medicaid Provider Manual,*
> *Mental Health and Substance Abuse Section,*
> *April 1, 2014, pp 114-115.*

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need for beneficiaries:

> 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. (Emphasis added).

Medicaid Provider Manual
Mental Health and Substance Abuse Section,
April 1, 2012, p 112

SCS's Children's Services Administrator testified that she holds a Master's Degree in Social Work from [redacted] University and has over 18 years of experience working with persons with developmental disabilities. SCS's Children's Services Administrator indicated that she supervises the Supports Coordinators who work with Appellant and has been involved in Appellant's case since he began receiving services through SCS in [redacted]. SCS's Children's Services Administrator testified that she has had interaction with Appellant and his mother and has reviewed all of the documents in Appellant's file. SCS's Children's Services Administrator indicated that she believes the Social Assessment completed by Appellant's Supports Coordinator accurately reflects Appellant's diagnoses and his current needs. SCS's Children's Services Administrator pointed out that the Social Assessment recommended continued CLS services for Appellant to increase his independence and community inclusion as well as his habits for physical health. SCS's Children's Services Administrator testified that the recommendations from the Social Assessment were incorporated into Appellant's IPOS and then the Supports Coordinator used the CLS Services Worksheet and a CLS Service Profile to properly determine how many 15 minute units of CLS Appellant would need each week to meet the goals in his IPOS. SCS's Children's Services Administrator testified that in her clinical judgment, the 29 15-minute CLS units per week were adequate to meet Appellant's needs and goals. SCS's Children's Services Administrator did indicate that should Appellant's behaviors worsen during the year, his mother can always request an increase in CLS.

[redacted]'s Contract Manager testified that he also has a Master's Degree in Social Work and has over 20 years of experience working with persons with developmental disabilities. [redacted]'s Contract Manager indicated that in the instant case he was asked to review the clinical information in Appellant's file following Appellant's mother's request for hearing. [redacted]'s Contract Manager testified that the clinical work done by SCS was appropriate and he agreed with the determination of CLS services for Appellant. [redacted]'s Contract Manager indicated that use of the CLS Services Worksheet and the CLS Service Profile was necessary to ensure consistency between providers and consistency in services provided to consumers.

Appellant's mother testified that Appellant lives in a single parent home and she has no immediate family in the State. Appellant's mother testified that she is concerned that Appellant's condition will worsen as his services are reduced. Appellant's mother indicated that Appellant's CLS services have been reduced by 54% in the past few years and, as services are continually taken away, she is concerned that the bottom will simply fall out and there will be a crisis. Appellant's mother testified that she is particularly concerned that Appellant's CLS hours are being reduced at this point in time because Appellant will be beginning high school in the fall.

Based on the evidence presented, it is determined that Respondent's process for determining CLS services, including use of the CLS Services Worksheet and the CLS Service Profile, is a proper and authorized tool for determining CLS levels for the consumers Respondent serves. The clinician who completed the most recent CLS assessment for Appellant took into account Appellant's needs and the specific goals in his IPOS. The CLS assessment was also reviewed by SCS's Children's Services Administrator, who concurred with the findings, as well as [redacted]'s Contract Manager, who also concurred with the findings. Appellant's mother does not take issue with the fact that Appellant's condition has improved; rather, she is simply worried that his condition will worsen if his CLS services are again reduced. However, if Appellant's condition were to worsen, Appellant's mother can contact Respondent and CLS hours can be increased almost immediately, if needed. Furthermore, given that the amount of Appellant's CLS services are based on his needs and behaviors, it is only natural that his CLS services would decrease as his needs decrease and his behaviors improve.

Ultimately, Respondent has a mandate to allocate the limited funds it receives from the State to provide services to all eligible persons in its service area and the CLS process here is an acceptable tool for meeting that mandate. As indicated above, "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."

Appellant bears the burden of proving by a preponderance of the evidence that additional CLS services are medically necessary. Based on the foregoing analysis, Appellant has failed to meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly calculated Appellant's CLS services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]
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Decision and Order

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.