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. 14-014776 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], Authorized Hearing Representative, appeared and testified on Appellant's behalf. [redacted], Appellant's mother and guardian and [redacted], caregiver, appeared as witnesses.

[redacted], Fair Hearings Officer, represented [redacted], the mental health authority for Michigan (CMH or [redacted]). [redacted], Supervisor, Housing Resource Team, appeared as a witness for the CMH.

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 anxiety disorder, profound mental retardation, infantile cerebral palsy, and mucopolysaccharidosis, a genetic disorder. (Exhibit F, pp 1, 11; 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. (Exhibit D; Testimony)

3. Appellant lives in an Adult Foster Care (AFC) home. (Exhibit F, p 2; Testimony).

4. Appellant's natural supports consist of his parents and two older brothers. Appellant's mother is his guardian and his father is his representative payee. (Exhibit F, p 5; Testimony)

5. Appellant currently attends [redacted] as part of his Special Education Program. (Exhibit F, p 5; Testimony)

6. In [redacted], Appellant's Supports Coordinator completed a Psychosocial 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 in his parent's home, where he was living at the time, while working towards a residential placement outside of his parent's home. (Exhibit F; Testimony)

7. After Appellant moved to the AFC home, Appellant's Supports Coordinator completed a Personal Care Worksheet and a B3/CLS Support Needs Worksheet in order to determine Appellant's Personal Care needs and how many 15 minute units of CLS Appellant would need each week in his AFC home. Through this process, Appellant's Supports Coordinator recommended that Appellant receive 13 points towards Personal Care (PC) needs and that 110 15-minute units of CLS per week be authorized. (Exhibit E, pp 1-3; Exhibit F; Testimony)

8. The Supervisor of [redacted]'s Community Housing Resource Team reviewed the information submitted by Appellant's Supports Coordinator and, while he agreed with the PC scoring of 13 points, he did not agree that the documents submitted supported the level of CLS requested. As such, the Supervisor determined that Appellant was entitled to 70 CLS hours per week based on the submitted documentation. (Exhibit D; Testimony)

9. On [redacted], [redacted] sent Appellant a Notice of Action indicating that his request for 110 CLS hours per week was denied, but that 70 CLS hours per week were authorized. (Exhibit B; Testimony)

10. On [redacted], Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (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. 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**
>
> 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,
October 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).

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 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).
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> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Section,*
> *April 1, 2012, p 112*

CMH's Housing Resource Supervisor testified that he holds a Bachelor's Degree in Social Work, has over 42 years of experience working with persons with developmental disabilities, and has been working at [redacted] for about [redacted] years. CMH's Housing Resource Supervisor indicated that he supervises the Housing Resource Team and the Community Placement Team, who make determinations regarding CLS and Personal Care for consumers who live in a licensed setting, like Appellant. CMH's Housing Resource Supervisor testified that he conducted the utilization review of the request received from Appellant's Supports Coordinator and reviewed all of the relevant documents from Appellant's file in conducting that review. CMH's Housing Resource Supervisor testified that the CMH's budget is fixed and that they were over budget in Fiscal Year [redacted]. (See Exhibit G). CMH's Housing Resource Supervisor testified that AFC homes provide supervision, community activities, and socialization as part of their contract and that the CMH cannot duplicate services provided by the AFC home. CMH's Housing Resource Supervisor indicated that the CLS and PC provided to consumers in an AFC home is to cover needs and services above and beyond what the AFC home is required to provide and to provide teaching and training opportunities for consumers in AFC homes.

With regard to his review of the Supports Coordinator's recommendation with regard to CLS hours, CMH's Housing Resource Supervisor testified that he removed the CLS units recommended for laundry and routine household care and maintenance because he determined that based on Appellant limited functioning, he would not be able to learn and maintain the skills necessary to assist with those tasks. CMH's Housing Resource Supervisor indicated that he reduced the recommended CLS units for socialization and relationship building, as well as for leisure choice and participation in regular community activities from 21 to 7 per week each because it appeared that much of the time spent with Appellant by CLS workers was for supervision, not socialization or community activities; which would not be supported by CLS. CMH's Housing Resource Supervisor also indicated that he reduced the number of CLS units of transportation from 6 to 4 per week to reflect the fact that less transportation would be needed with the reduction in CLS units for socialization and leisure activities. Based on these changes, CMH's Housing Resource Supervisor determined that 70 CLS units per week were all that were medically necessary for Appellant.

Appellant's representative testified that Appellant should be allocated some CLS units for meal preparation because Appellant has food allergies, his food needs to be pureed, and he sometimes has to be fed hand over hand, all of which are above the requirements of an AFC home. (Exhibit F, p 3) Appellant's representative also testified that he believed Appellant should be allocated some CLS units for routine household chores because working on such tasks would help Appellant with his fine motor skills, which is one of the goals in Appellant's Plan of Service. (Exhibit F, p 26) Appellant's representative testified that he believed Appellant should be allocated CLS units for Activities of Daily Living (ADL's) because everything takes longer with Appellant because of his behavioral issues. (Exhibit F, pp 21, 26, 28) Appellant's representative pointed out that Appellant requires breathing treatment twice per day and that each treatment takes 30 minutes, which leaves very little CLS units during the day for anything else. Appellant's representative testified that Appellant only sleeps 2-3 hours per night so the AFC home had to hire an overnight staff person given that Appellant has elopement issues and is prone to injuring himself if left unsupervised. (Exhibit F, p 3) Appellant's representative indicated that Appellant needs more CLS for socialization because he struggles with personal boundaries when around others and CLS units could assist with this issue. (Exhibit F, p 31) Appellant's representative indicated that Appellant needs more than 4 CLS units per week for transportation because his health has declined since he entered the home and he goes to the doctor at least once or twice per week, with each trip taking 1-3 hours. Appellant's representative testified that Appellant needs more CLS for leisure activities because he requires more staff on outings because of his behavioral issues. Appellant's representative testified that Appellant should have been allocated some CLS units per week for reminding, observing and/or monitoring of medication administration because Appellant uses a nebulizer and his medications need to be fed through a soft-serve diet three times per day, which would be above and beyond the requirements of an AFC home. Finally, Appellant's representative indicated that Appellant needs more than the 30 units of CLS authorized for health and safety because, as indicated above, Appellant needs one on one staff at night due to his self-injurious behaviors.

Appellant's mother testified that she is very disappointed in the assessment and authorization of CLS units in Appellant's case as the recommendations are way off from what Appellant needs. Appellant's mother testified that she and Appellant's father can no longer take Appellant on the weekends because they have their own health issues. Appellant's mother testified that she wants Appellant to become a productive member of society and she feels that the CMH's actions here are taking that possibility away from Appellant.

Based on the evidence presented, it is determined that Respondent's process for determining CLS services, including use of the Personal Care Needs Worksheet and the B3/CLS Support Needs Worksheet, is a proper and authorized tool for determining CLS levels for the consumers Respondent serves. The clinician who completed the utilization review of the recommendation made by Appellant's Supports Coordinator took into account Appellant's needs and the specific goals in his IPOS. Clearly, Appellant had not been living in the AFC home for a significant period of time when this first review was done, so it very possible that Appellant's CLS units may increase during the next review, scheduled for a little over a week from the hearing date. However, based on the information the CMH had at the time of the decision, the decision was supported by the evidence in the record.

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 Network 180 properly calculated Appellant's CLS services.

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: 1/7/2015

***** 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.