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. 14-015338 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. Appellant also appeared and testified. [redacted], Director, Healthcare Providers, appeared as a witness.

[redacted], Manager, Due Process, represented [redacted] County Community Mental Health Authority, (CMH or Department). [redacted], Supports Coordinator Supervisor, [redacted], Unit Director Supports Coordinator; and [redacted], Compliance Coordinator, appeared as witnesses 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 has been receiving supports and services through CMH. (Exhibit A, p 1; Testimony).

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony)

3. Appellant lives in a 24/7 supported residence with a roommate, who also receives supports and services through CMH. (Exhibit A, p 9-10; Testimony).

4. Appellant's natural supports consist of her mother and a few friends. (Exhibit A, pp 7-8; Testimony)

5. Appellant uses an electric wheelchair for mobility and requires assistance for many activities due to her physical limitations. Appellant is able to direct her own care and she receives a CLS per diem for shared staffing supports as well as individual one on one CLS hours to participate in activities without her roommate. Appellant can be alone in the community with a friend, caregiver, or family member. (Exhibit A, pp 6-24; Testimony)

6. Appellant also receives 69 hours per month of Adult Home Help services through the Department of Human Services to assist her with household chores and care. (Exhibit A, p 13; Testimony)

7. On [redacted], Appellant was informed that her one on one CLS hours would be reduced from 19 hours per week to 4.5 hours per week. Following an administrative review, the action was rescinded and Appellant's one on one CLS hours were reinstated to 20 hours per week, the amount authorized in her [redacted] Individual Plan of Service (IPOS). (Exhibit A, p 1; Testimony)

8. On [redacted], following a review of her CLS needs, Appellant was informed that her one on one CLS would be reduced from 20 hours per week to 8 hours per week. Appellant requested that her CLS hours only be reduced to 12 hours per week. (Exhibit A, pp 1, 26-36; Testimony)

9. On [redacted], CMH sent Appellant a Notice of Action indicating that her CLS hours were being reduced to 8 hours per week. (Exhibit A, pp 3-4; 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 Supports Coordinator Supervisor testified that he holds a Bachelor's Degree in Social Work and has worked at [redacted] ([redacted]) for over 15 years. CMH's Supports Coordinator Supervisor indicated that as supervisor he reviews requests for CLS submitted by supports coordinators on behalf of beneficiaries. CMH's Supports Coordinator Supervisor indicated that in the instant case he reviewed Appellant's IPOS, her goals, met with staff and supervisors, and with Appellant and concluded that the decision to reduce Appellant's CLS hours to 8 hours per week was proper. CMH's Supports Coordinator Supervisor testified that Appellant uses her one on one CLS hours to attend Physical Therapy for 4 hours per week, leaving the remaining 4 hours available for Appellant to meet her other goals regarding community activities. CMH's Supports Coordinator Supervisor indicated that Appellant also has shared supports with her roommate, so she and the roommate are able to participate in community activities together. CMH's Supports Coordinator Supervisor also indicated that some of the shared CLS hours (3 hours per week) can also be used by Appellant

individually because Appellant's roommate can be left alone for 3 hours per week. Based on his review of the records, CMH's Supports Coordinator Supervisor concluded that 8 CLS hours per week, when combined with Appellant's other shared supports, and her informal supports, were sufficient in amount, scope and duration to meet the goals in Appellant's IPOS.

Appellant's provider testified that CLS hours are also important to Appellant for skill building, not just for community activities. Appellant's provider indicated that they are trying to teach Appellant to be more independent in the community by teaching her to handle her own money and get to and from places more independently. Appellant's provider testified that Appellant's physical therapy (PT) is now increased to 6 hours per week, so after PT, Appellant only has 2 CLS hours per week to meet all of the goals in her plan. Appellant's provider also indicated that additional CLS hours are important to Appellant so that she can have more time away from her roommate and develop some individual friends and supports.

Appellant testified that the reduced CLS hours also makes it more difficult to visit family and that with the reduced hours she cannot be flexible with her hours and save up hours to make longer trips, such as to her uncle's home in Indiana.

Appellant's mother testified that she is very disappointed in the reduction of Appellant's CLS hours. Appellant's mother indicated that Appellant is brilliant and that this reduction is holding her back from her full potential. Appellant's mother also indicated that this whole process has seriously affected both Appellant's physical and mental health.

Based on the evidence presented, it is determined that Respondent followed proper policy in determining the number of medically necessary CLS hours for Appellant. The clinician who completed the utilization review took into account Appellant's needs and the specific goals in her IPOS. At the time the decision was made, Appellant was using 4 CLS hours per week for PT, which left her with 4 CLS hours for community integration and community activities. Clearly, Appellant's situation has changed some since the decision was made in [redacted], given that she now attends PT 6 hours per week and she will soon not be able to use her roommate's 3 CLS hours each week because the roommate is scheduled to have surgery, but neither of those situations were present when the decision was made. 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 used here is an acceptable method 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."

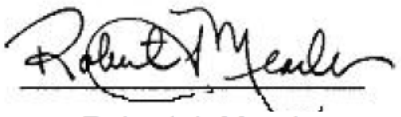
Appellant bears the burden of proving by a preponderance of the evidence that additional CLS services are medically necessary. Based on the foregoing analysis, Appellant has failed to meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH 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: [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.