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

IN THE MATTER OF:

Docket No. 14-017475 CMH

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, an in-person hearing was held on [redacted], an attorney with [redacted] represented Appellant [redacted]. Appellant and [redacted], Appellant's mother, testified as witnesses for Appellant. [redacted], Medicaid Fair Hearings Officer, represented the Respondent [redacted] Community Mental Health Authority (CMH). [redacted], attorney, appeared on behalf of Community Living Services, Inc. [redacted] Supports Coordinator Supervisor, and [redacted], Supports Coordinator, from CLS testified as witnesses for Respondent.

ISSUE

Did the CMH properly deny Appellant's request for [redacted] hours per week of Community Living Supports (CLS) and, instead, only authorize [redacted] hours per week of such services?

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 Medicaid covered services to beneficiaries who reside in its service area.

2. In turn, it contracts with Community Living Services, Inc. to provide and oversee services.

3. Appellant is a [redacted] year-old Medicaid beneficiary who has been diagnosed with Autistic Disorder and Moderate Intellectual Disability. (Exhibit B, Annual Social Summary, page 1 of 6).

4. Appellant has been receiving services through the CMH and Community Living Services, Inc., including supports coordination; skill-building, supported employment, and CLS. (Exhibit A, pages 6-7; Exhibit B, Personal Plan, page 9 of 13).

5. In her previous person-centered plan, Appellant's only goal involving CLS was for community integration and inclusion, and she was approved for [redacted] hours per week of such services. (Testimony of [redacted]

6. However, Appellant was actually utilizing, and Community Living Services, Inc. was paying for, [redacted] hours per week of CLS. (Exhibit B, Personal Plan, page 9 of 13; Testimony of [redacted]; Testimony of [redacted]).

7. Appellant also receives Home Help Services (HHS) through another Medicaid program. (Testimony of [redacted] Testimony of [redacted].

8. Appellant's previous person-centered plan was set to expire on [redacted] and a person-centered planning meeting was scheduled for [redacted]. (Exhibit B, Personal Plan, page 1 of 13).

9. Appellant's supports coordinator did not ask for any progress notes or provider logs prior to the person-centered plan meeting, but she did ask Appellant and Appellant's mother for documentation related to Appellant's HHS. (Testimony of [redacted].

10. She also attempted to schedule a home visit with Appellant. (Testimony of [redacted]).

11. However, no HHS documentation was provided and, while Appellant's mother told the supports coordinator that she would contact her about scheduling a home visit, Appellant's mother never did so and no visit was conducted. (Testimony of [redacted] Testimony of [redacted]).

12. Based on information contained in Appellant's file, her supports coordinator came into the person-centered plan meeting on [redacted], expecting to only authorize [redacted] hours per week of CLS. (Testimony of J[redacted]

13. During the meeting itself, Appellant and her mother requested a continuation of [redacted] hours per week of CLS. (Testimony of [redacted]; Testimony of [redacted]).

14. Appellant's supports coordinator and mother discussed the request for [redacted] hours per week, but the supports coordinator did not ask what the hours were to be used for or what assistance Appellant's current CLS workers were providing. (Testimony o[redacted]

15. Appellant's supports coordinator also did not ask Appellant or Appellant's mother about any other goals Appellant might have that would involve CLS. (Testimony of J[redacted].

16. During the person-centered plan meeting, Appellant's supports coordinator verbally told Appellant's mother than only [redacted] hours of CLS per week would be approved. (Testimony of [redacted].

17. She also provided Appellant with a written Adequate Action Notice stating that the services Appellant requested will be authorized per completion of the plan and that Appellant had a right to appeal. (Exhibit A, pages 4-5; Testimony of [redacted]

18. However, according to Appellant's supports coordinator's supervisor, it was improper for the supports coordinator to make a decision prior to or at the person-centered plan meeting. (Testimony of [redacted]).

19. The supports coordinator's supervisor also testified that she reviewed this case with Appellant's supports coordinator after the meeting and they decided to only approve [redacted] hours per week of CLS. (Testimony of [redacted].

20. On [redacted] r[redacted], Community Living Services, Inc. sent Appellant a copy of the approved Personal Plan. (Exhibit B, Personal Plan, pages 1-13).

21. In that plan, Appellant was approved for [redacted] hours per week of CLS. (Exhibit B, Personal Plan, page 5 of 13).

22. The only specific goal relating to CLS in the person-centered plan involved community integration and inclusion. (Exhibit B, Personal Plan, pages 3-4 of 13).

23. However, the person-centered plan also provided that Appellant's staff will assist Appellant during sleeping hours, by visually checking her [redacted] hour; awake hours, by visually checking on her every [redacted] minutes; and bathing, by guiding, directing, monitoring, ensuring the proper temperature, and providing hands-on assistance as needed. (Exhibit B, Personal Plan, pages 3-4 of 13).

24. The plan sent to Appellant further advised her that, if she was dissatisfied with her plan or services, she should discuss her concerns with her supports coordinator or Customer Services at Community Living Services, Inc. (Exhibit B, Personal Plan, page 10 of 13).

25. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this case. (Exhibit A, pages 2-3).

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

Additionally, 42 CFR 430.10 states:

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act also provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided pursuant to that waiver are CLS and, with respect to that service, the applicable version of the Medicaid Provider Manual (MPM) states:

> **17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/14]**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. **(text added 7/1/14)**
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
> - shopping for food and other necessities of daily living
>
> CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals

with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

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

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments

- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

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

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as

> bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
>
> *MPM, October 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 122-123*
> *(Internal highlighting omitted)*

However, while CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM states:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - that are experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

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

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

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s) [CHANGE MADE 7/1/14]

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid

State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment. **(text added 7/1/14)**

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports

> must be documented in the beneficiary's individual plan of service.
>
> Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.
>
> *MPM, October 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 119-120*
> *(Internal highlighting omitted)*

Here, it is undisputed that Appellant requires some CLS and it is only the amount of hours to be authorized that is at issue, with Appellant requesting a continuation of [redacted] hours per week of CLS and the CMH only authorizing [redacted] hours per week of such services.

Appellant and her representative bear the ultimate burden of proving by a preponderance of the evidence that the CMH erred in denying the request for additional CLS hours, while the CMH also has the initial burden of going forward and demonstrating that its decision was in accordance with law and policy.

As a preliminary matter, Appellant's representative first argues that the CMH failed to provide proper notice of its decision. The CMH must send written notice when it takes a negative action, such as the denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *See* 42 CFR 438.400 *et seq.* Additionally, 42 CFR 438.404(b) specifically requires that the notice include, among other things, a statement of the action or intended action, the reasons for the action, and an explanation of the right to appeal.

Given the record in this case, it does not appear that proper notice was ever provided. Appellant's supports coordinator verbally informed Appellant at the person-centered plan meeting that the request for [redacted] hours per week of CLS was denied and that, instead, only [redacted] hours per week of such services would be approved. However, she did not provide Appellant with written notice of that decision and the written adequate action notice she did provide at the time only stated that the services Appellant requested would be authorized after completion and approval of the plan.

Moreover, while the copy of the completed person-centered plan sent to Appellant on [redacted], also provided that only [redacted] hours per week of CLS, it did not explain why and it only advised Appellant that, if she was dissatisfied with her plan or services, she should discuss her concerns with her supports coordinator or Customer Services at Community Living Services, Inc.

[redacted] further testified that she sent Appellant a letter on [redacted] clarifying the reasons for the partial denial of CLS. However, any such letter would have been sent almost [redacted] months after the decision was made and, regardless, it was not submitted as an exhibit at the hearing and it is unclear if it even complied with the requirements set forth in the Code of Federal Regulations.

Accordingly, the undersigned Administrative Law Judge finds that the CMH failed to provide proper notice in this case and its decision should be reversed on that basis.

In addition to arguing that any notice was defective, Appellant's representative also argues that the CMH's final decision was improper. Given the record in this case, the undersigned Administrative Law Judge finds that Appellant is correct, the CMH's decision was improper, and that the decision should therefore be reversed on that basis as well.

Appellant's supports coordinator expressly testified that, based on the information contained in Appellant's file, she came into the person-centered plan meeting expecting to only authorize [redacted] hours per week of CLS and that she did in fact make the final decision to only authorize [redacted] hours per week during the meeting. However, her own supervisor subsequently testified that the supports coordinator acted improperly by making a decision prior to or at the person-centered plan meeting. According to the supervisor, person-centered planning is meant to be a process for planning and supporting a participant that should have involved Appellant and her family; addressed her needs and desires; and included the supervisor's review.

Moreover, even assuming that making the decision on hours at the meeting was appropriate, the decision itself was improper. Appellant's supports coordinator correctly testified in support of the decision that, while both were requested, no documentation regarding Appellant's HHS was provided and, due to Appellant's mother, no home visit was conducted. However, she also relied on the lack of progress notes or provider logs, despite the fact that no such documents were requested prior to the person-center plan meeting or the decision on hours being made.

By her own admission, the supports coordinator also failed to even discuss what the CLS hours were to be used for or what assistance Appellant's current CLS workers were providing at the time. The single goal relating to CLS in Appellant's person-centered plan had not changed and the person-centered plan also identified additional needs and assistance that the CLS workers were addressing, including visual checks [redacted] at night; visual checks every [redacted] minutes during the day; and guiding and monitoring assistance with bathing. Appellant's coordinator appeared to have no knowledge of such needs during the hearing and, despite the fact that they were expressly identified in the plan, it does not appear that any such needs were accounted for in the decision to only approve [redacted] hours per week of CLS.

While the undersigned Administrative Law Judge finds that the CMH's decision must be reversed both because of defective notice and the improper decision, it is not clear that Appellant is ultimately requires the [redacted] hours per week that she seeks. Accordingly, the CMH will only be ordered to initiate a reassessment of Appellant's request for [redacted] hours per week of CLS.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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

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.