STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-001990 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 telephonic hearing was held on [redacted]. Appellant appeared but did not testify. [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted] appeared as a witness on behalf of Appellant.

The following individuals appeared as witnesses on behalf of Respondent [redacted] Community Mental Health (CMH), subcontractor with the MDCH: [redacted], Assistant Coordinator to Due Process; [redacted], Manager of Due Process for [redacted]. The following two witnesses appeared on behalf of the [redacted] Community Living Services (CLS) subcontracting with the CHM: [redacted], Assistant Director of Community Supports, and [redacted], Self Determination Coordinator.

ISSUE

Did the Community Living Services of [redacted] properly deny Appellant's request to increase his Community Living Supports (CLS) hours from [redacted] hours per week to [redacted] hours per week?

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 male Medicaid beneficiary, receiving services through Macomb County Community Mental Health (CMH). (Exhibit A.21; 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. (Testimony)

3. Community Living Services of [redacted] is under contract with the CMH to provide Medicaid covered services to eligible individuals in Oakland County.

4. Appellant is diagnosed with mental illness, Stage II liver disease, renal failure, and neurogenic bladder. (Exhibit A). In [redacted], Appellant underwent a total colectomy, increasing his needs with the ileostomy bag, wound care, peg tube, and tube feeding. (Exhibit A; Testimony). Appellant's parent testified that at this point, Appellant attended school less often. (Testimony.

5. Appellant lives with his family in a private residence. (Exhibit A.1).

6. On [redacted] CLS conducted a review and certified a review period from [redacted] 4 to [redacted]. (Exhibit A.21).

7. Appellant's current plan has Appellant receiving 47 hours of CLS per week; 24 days per diem in respite care; an increase in the Home Help Services (HHS) grant from the Michigan Department of Human Services from $[redacted] to $[redacted] (or an increase to [redacted] hours per month) effective [redacted],

8. Appellant requested an increase to [redacted] hours per week. (Exhibit A.1; Testimony). On [redacted] CLS denied the request on the grounds that "…CLS has authorized [redacted] hours per week which is sufficient in amount, scope, and duration to reasonably achieve the outcomes identified in the person-centered plan." (Exhibit A.34). Other services are summarized on Exhibit A.4.

9. CLS subsequently requested information from Appellant regarding the specific HHS grant and hours for activities of daily living and instrumental activities of daily living. Appellant informed CLS of the amount of increase but refused to give any information, including the reward letter, that lists the amount of hours allocated per task. (Testimony).

10. The CLS goals in Appellant's most recent Person Centered Plan (PCP) include Appellant attending school as much as possible, gain greater access to and integration with the community, learn to increase his independence, make connects in his community and begin to enhance his life and decrease his dependence on his family. (Exhibit A.).

11. On [redacted] and subsequently on separate statement, Appellant filed a request for a hearing was received with the Michigan Administrative Hearing System. Appellant stated in part that he was requesting the

> hearing on the grounds that he has to be catherized 4 times a day; ileostomy bag has to be emptied throughout the day; a peg tube needs wound care 3 times a day; not always able to go to school program and need additional hours; and the need for more CLS hours as school days are less due to health and will be out of school [redacted]. (Hearing Requests).

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. CMH 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 CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. It states, in relevant part:

> **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.

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, (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 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.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
July 1, 2014, pp 112, 114-115.

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/Substance Abuse Chapter
July 1, 2014, pp 12-14

Here, the Department denied an increase in Appellant's CLS hours on the basis that the assessment indicates that services are being delivered consistent with the goals and objectives of the PCP. Respondent also indicated that medically necessity was not shown based on the facts available, in part, due to Appellant refusing to verify HHS tasks so that the CLS could make a determination as required under the MPM 17.3.B Section.

Appellant argues that due to the total colectomy in [redacted], that he has greater medical needs (with the ileostomy bag, wound care, peg tube, and tube feedings), that he cannot attend school as much, that almost the entire grant is already used before the expiration of the certification period, that Appellant's mother works 10 hours per day, and that the hearing representative chose to go forward with an administrative hearing instead of disclosing and/or verifying the specifics regarding the HHS grant and the

increase(s).

First and foremost, it should be established that the purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record, upon the evidence of record focusing at the time of the assessment. The Department cannot be held accountable for evidence it was unaware of at the time of its determination.

This ALJ cannot surmise or guess as to the allocation of the increase of the HHS grant any more than the CLS can. Federal and state law requires the Respondent to make a determination if the CLS services supplant the HHS services. If the Respondent were to offer services already offered by the DHS, the Respondent could be subject to substantial financial penalties. Individuals requesting services have the burden of proof to establish eligibility. Recipient files must contain sufficient verification(s) to establish eligibility. Again, failure to have sufficient verification(s) in a recipient's file can subject the Respondent to financial penalties. The relationship here requires Appellant to cooperate to establish eligibility; failure to do can result in ineligibility. Due to Appellant refusing to disclose the allocation of the HHS grant, the Respondent is unable to assess medical necessity as required under the MPM as well as whether the CLS services supplant the HHS grant. Thus, for this reason alone, the decision must be upheld.

In addition, it is noted that a number of the Appellant's statements regarding the reason for requesting an increase in hours are not anticipated by the MPM as to the mandates and eligibility requirements found in the mental health/substance about chapter. Specifically, CLS hours are not a substitute for school; personal care needs identified by Appellant are not CLS hours but more generally addressed by the ADLs and specialized care needs of the HHS program administered by the Michigan Department of Human Services; that the Appellant's parent works 10 hours per day is not controlling as to the amount of hours; and Appellant failed to participate in a training that would assist her in allocating the hours during the certification period. It is noted that Appellant seemed confused by the review period; however, the time period is clearly indicated in the evidentiary packet.

Appellant is not authorized to use CLS hours and services are in a manner that is not consistent with the goals and objectives outlined in the PCP.

Appellant bears the burden of proving by a preponderance of the evidence that [redacted] hours of CLS per week are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing [redacted] hours per week of CLS for Appellant. Appellant failed to prove by a preponderance of the evidence that additional hours of CLS was medically necessary.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health
and Human Services

cc: [redacted]

JS[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.