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) 373-4147

IN THE MATTER OF

[redacted],

Appellant

Docket No. 15-015695 CMH
Case No. [redacted]

_____/

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]. Appellant is in residential placement. [redacted], Appellant's sister/Legal guardian, and [redacted], Appellant's brother, appeared and testified on Appellant's behalf.

[redacted], Assistant Corporate Counsel ([redacted]), represented [redacted] County Community Mental Health (CMH or Respondent). [redacted], [redacted] Manager, appeared as witness for the Respondent.

ISSUE

Did the CMH properly deny Appellant's Community Living Supports (CLS) hours?

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, date of birth [redacted].

2. Appellant has been diagnosed with Impulse Control NOS, mild cognitive disorder, cerebral palsy, seizure disorder, recurrent encephalopathy with hyperammonemia, hepatitis C, recurrent pneumonia, dysphagia (feeding tube), recurrent urinary tract infection, incontinence of urine (requires catheritization four times daily) soft mechanical diet due to swallowing difficulties and choking risk, and fall risk.

3. CMH is under contract with the Department of Health and Human Services (DHHS) to provide Medicaid covered services to people who reside in the CMH service area.

4. On [redacted], Appellant was admitted to [redacted] Rehabilitation Center in [redacted] County.

5. Initially, due to her need for specialized ventilator and tracheotomy care 1:1 CLS staff was authorized by the Respondent on a short term basis to facilitate the transition from the [redacted] Psychiatric Hospital.

6. On [redacted], the Respondent sent Appellant's guardian notice that 64 units of Community Living Supports (CLS) provided to Appellant would be terminated effective [redacted], because the CLS were not medically necessary.

7. On [redacted], the Michigan Administrative Hearing system received a request for a hearing contesting the cancellation of the CLS hours. Attachment B page 9

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 Health and Human Services (formerly Department of Community Health) operates Sections 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services (MDHHS) 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

The Medicaid Provider Manual provides, in pertinent part:

> **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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- 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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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. (Emphasis added)

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;
- 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 Chapter
January 1, 2014, pp 12-14

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its 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.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
January 1, 2014, pp 113-114.

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 that are needed to reasonably achieve those goals.

10.19 MEDICALLY-RELATED SOCIAL SERVICES

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include, for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

10.20 MENTAL HEALTH SERVICES

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as having a mental illness or intellectual disability. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Medicaid Provider Manual
Nursing Facilities Section
October 1, 2015

The CMH's representative testified that CLS staffing was meant to be transitional and only on a short term basis to facilitate the transition from the [redacted] Psychiatric Hospital to [redacted] Rehabilitation Center. Initially, Appellant had a need for specialized ventilator and tracheotomy care. At the [redacted] hospital, Appellant was easily agitated and was not taking medication as prescribed. She had significant issues including being in a wheelchair due to gait disturbance, punching, kicking and punching staff, poor impulse control, difficulty understanding things, poor communication, and attention seeking behaviors including defecating and urinating on herself to get someone to shower her and change clothes, walking around nude, and yelling. She threw things at others, hit others and was self-abusive.

Further, Appellant was approved for nursing home placement and moved to [redacted] to facilitate her transition to nursing home care. Community Living Services does not provide medical intervention. It was reported that Appellant was no longer agitated or pulling out her peg tube or a fall risk. Nor was she too much of a behavior problem for [redacted]ine staff to handle. After she had surgery on her ileus, Appellant was reported to be calmer. At that point, typical protocol for someone designated "specialized nursing home" care through their OBRA determination, if they had behavioral issues such as irritation, should be attended by the OBRA team regardless of county fiscal responsibility (COFR). OBRA is not a COFR service. Once the transition was made, CMH staffing was terminated. (State's Exhibit E pages 17-20)

Lastly, CLS would not meet medical necessity criteria set forth in Section 2.5A of the Medicaid Provider Manual.

Appellant's representative testified that Appellant is much calmer and receives better care with a sitter around to alert staff to Appellant's needs in a timely manner.

Based on the evidence presented, Appellant has failed to meet her burden of proof to show, by a preponderance of evidence, that she retains the medical necessity for CLS hours when she is approved for and receiving nursing home care. Based upon the evidence contained in the record, Appellant's medically necessary needs are being met now that she has transitioned from the psychiatric hospital to nursing home care. Medicaid policy explicitly states:

> CLS **<u>may</u>** be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services.

Thus, CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Appellant should no longer receive CLS services once she had transitioned to nursing home care. The provision of CLS services is not mandated in licensed specialized residential setting. CMH determined that the services were no longer needed and Appellant's representatives have not established that the CLS are medically necessary. The department's decision must be upheld under the

circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly determined that Appellant should no longer receive CLS hours once she transitioned to nursing home care.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[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.