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]

Docket No. 15-017415 CMH
Case No. [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*. upon the request for hearing filed on Appellant's behalf.

After due notice, an in-person hearing was held on [redacted]. Attorney [redacted] appeared on Appellant's behalf. [redacted], father and guardian; [redacted], mother, payee; [redacted], AFC House Manager; and [redacted], AFC owner and licensee, appeared as witnesses for Appellant.

Attorney [redacted] represented Respondent, [redacted] (CMH or Department). [redacted], former Developmental Disability (DD) Case Manager; and [redacted], Adult Operations Manager; appeared as witnesses for Respondent.

ISSUE

Did Respondent properly reduce 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. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in its service area. (Testimony)

2. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who has been diagnosed with tuberous sclerosis, hypotension, seizure disorder, osteoporosis, and depression. (Exhibits 1, 5, F, G, M, P; Testimony)

3. Appellant is ambulatory but non-verbal. Appellant had a GAF of 21 as of [redacted]. (Exhibits 1, 5, F, G, M, P; Testimony)

4. Appellant has resided in an Adult Foster Care (AFC) home since [redacted]. (Exhibits 1, 5, F, G, M, P; Testimony)

5. Appellant is enrolled in the Habilitation and Supports Waiver. Medicaid services are provided through [redacted] under a County of Financial Responsibility Agreement (COFR) with Respondent, [redacted]. Those services include personal care and comprehensive community supports in a specialized residential care setting, physical therapy and out-of-home Community Living Supports (CLS). The CLS are provided by [redacted], a subcontractor for [redacted]. (Exhibits 1, 5, F, G, M, P; Testimony)

6. Following a review of Appellant's records, CMH determined that the 8.75 CLS hours per week previously authorized for Appellant were no longer medically necessary. CMH based its decision on a review of a Psychosocial Assessment dated [redacted], documentation of outings provided to Appellant and other residents by the AFC home, and the logs of Appellant's CLS providers. (Exhibits 1, 3, 4; Testimony)

7. On [redacted], following Appellant's Individual Plan of Service meeting, CMH's Case Manager provided Appellant's father and guardian with an Advance Notice informing the family that Appellant's CLS hours were to be terminated effective [redacted] because CMH determined that CLS services were no longer medically necessary. (Exhibits 2, A; Testimony)

8. In a letter accompanying the Advance Notice and explaining the rationale for the decision, CMH's Case Manager indicated, in part:

* * *

> This conclusion was reached by review of the psychosocial assessment, stating that Jennifer has a physical therapy program providing walks 5-7 times weekly, and at least 2 outings a week in the AFC home that range from 2-4 hours each. Additionally, it was noted in her assessment that her parents remain very active in her life as well as other natural supports.
>
> Also, upon reviewing the CLS documentation from the [redacted] provider, the majority of time is spent walking in the mall. Over the last year, the use of this time has not increased [redacted] opportunity to experience what her community has to offer, which was the stated goal of this service. This is something that the comprehensive community supports provided at her home is addressing with her twice weekly outings.

* * *

(Exhibit A; Testimony)

9. Appellant's physical therapy (PT) is designed to address her osteoporosis by increasing her stamina, strength, and posture. PT is provided by staff in the AFC home who walk Appellant around the inside of the home and around the outside the home when the weather permits. Appellant's IPOS indicates that PT is not to be considered CLS time. (Exhibits 1, 5, M; X, Y; Testimony)

10. Outings from the AFC home are not 1 to 1 and usually involve 5-6 other residents. Appellant's IPOS states that AFC home outings can only be considered CLS time for Appellant if Appellant has a separate 1 to 1 caregiver during the outings. Between [redacted] and [redacted] only 18 of the 33 AFC home outings were 2 hours or more, contrary to the assertion of CMH's Case Manager. Appellant did not have a separate caregiver during any of the outings. (Exhibits 5, M, N, P, X, Y, BB; Testimony)

11. Appellant's parents take Appellant to all of her medical and other appointments, but regular social outings are rare. Appellant's brother visits Appellant approximately once per year and currently lives in [redacted]. He previously lived in [redacted]. The other two persons cited as natural supports in the Psychosocial Assessment dated [redacted] do not interact with Appellant at all. (Exhibits 1, 5, M; Testimony)

12. Contrary to the assertion of CMH's Case Manager, the majority of Appellant's CLS time was not spent "walking in the mall". CLS logs demonstrate that Appellant went to the mall 16 out of 49 outings between [redacted] and [redacted], or approximately 32.7% of the time. Nine (9) of those 16 trips involved other destinations besides the mall, which would further lower the percentage of time spent in the mall. While at the mall, Appellant did many other things besides walk; she rode the carousel, read books, played with toys at Barnes and Noble, played with and watched children in the play area, and ate food. (Exhibits 4, T, U, V, W, AA; Testimony)

13. Appellant's depression and self-injurious behaviors have increased during past periods when Appellant did not have 1 to 1 CLS. (Exhibits S, CC, DD; Testimony)

14. On [redacted] the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed on Appellant's behalf. (Exhibit E)

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.]
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> * * *
>
> 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.]

Moreover, 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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM) 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 Chapter*
> *July 1, 2015, pp 12-14*

With respect to the Habilitation Waiver and CLS, the MPM provides:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.
>
> HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:
>
> - Has a developmental disability (as defined by Michigan law);
> - Is Medicaid-eligible;
> - Is residing in a community setting;
> - If not for HSW services, would require ICF/MR level of care services; and
> - Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 WAIVER SUPPORTS AND SERVICES

Community Living Supports (CLS)

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.
- Assistance, support and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, 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 DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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 must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. 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.

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.
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> *Medicaid Provider Manual*
> *Mental Health/Substance Abuse Chapter*
> *July 1, 2015, pp 96-98*

Here, Appellant has appealed the decision by CMH to terminate authorization for the 8.75 CLS hours per week previously authorized.

Based on the evidence presented, Appellant has proven, by a preponderance of the evidence that CMH's termination of her 8.75 CLS hours per week was improper. CMH asserted that the termination of CLS was proper because Appellant had a physical therapy program providing walks 5-7 times weekly, at least 2 outings a week in the AFC home that ranged from 2-4 hours each, and parents and other natural supports who were able to provide Appellant with outings to meet her goals of community inclusion and participation. CMH also asserted that the CLS Appellant had been engaged in was improper because it consisted of mostly walking in the mall. CMH based these conclusions on a review of a Psychosocial Assessment dated [redacted], documentation of outings provided to Appellant and other residents by the AFC home, and the logs of Appellant's CLS providers. And, while at first glance a cursory review of those documents would seem to support the CMH's conclusion, a thorough review of those documents shows that the conclusions reached are not supported.

First, Appellant's physical therapy (PT) is designed to address her osteoporosis by increasing her stamina, strength, and posture and is provided by staff in the AFC home who walk Appellant around the inside of the home and around the outside the home when the weather permits. Walking around the house, and even around the outside of the house, in no way supports Appellant's goal of community inclusion and participation. Furthermore, Appellant's IPOS indicates specifically that PT is not to be considered CLS time.

Second, outings from the AFC home are not 1 to 1 and usually involve 5-6 other residents. Between [redacted] and [redacted], only 18 of the 33 AFC home outings were 2 hours or more, contrary to the assertion of CMH's Case Manager. And, Appellant's IPOS states that AFC home outings can only be considered CLS time for Appellant if Appellant has a separate 1 to 1 caregiver during the outings. Appellant did not have a separate caregiver during any of the outings.

Third, while Appellant does have very supportive parents, they spend their energies taking care of Appellant's daily needs by taking Appellant to all appointments outside of the AFC home. Appellant's social outings with her parents are rare. And the "other" natural supports referred to by CMH to justify its decision to terminate Appellant's CLS consist of Appellant's brother, who visits Appellant approximately once per year and currently lives in [redacted] and two other family friends who do not interact with Appellant at all.

Fourth, contrary to the assertion of CMH's Case Manager, the "majority" of Appellant's CLS time was not spent "walking in the mall". CLS logs demonstrate that Appellant went to the mall 16 out of 49 outings between [redacted] and [redacted], or approximately 32.7% of the time. Nine (9) of those 16 trips involved other destinations besides the mall, which would further lower the percentage of time spent in the mall. And, while at the mall, Appellant did many other things besides walk; she rode the carousel, read books, played with toys at [redacted], played with and watched children in the play area, and ate food.

Finally, records indicate that Appellant's depression and self-injurious behaviors have increased during past periods when Appellant did not have 1 to 1 CLS. However, CMH did not seek out these records, speak to Appellant's parents, or her caregivers before making the decision to terminate Appellant's CLS. As Appellant correctly points out, decisions regarding medical necessity must be "[b]ased on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary"; and be "[b]ased on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary." Here, CMH simply reviewed a few distinct files from Appellant's file without reaching out to Appellant's parents, caregivers, or medical providers for information. Such a review is not sufficient to meet the criteria required for medical necessity determinations under the MPM.

Given the above, it cannot be said that CMH's decision to terminate Appellant's CLS was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly terminated Appellant's 8.75 CLS hours per week.

IT IS THEREFORE ORDERED that:

Respondent's decision to reduce Appellant's CLS is REVERSED.

Appellant's CLS hours shall be reinstated to 8.75 hours per week within 10 days of the receipt of this Order.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of
Health and Human Services

RJM/cg

Date Mailed: [redacted]

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.