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. 15-019973 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, a hearing was held on [redacted]. [redacted], Appellant's father, appeared and testified on Appellant behalf. Appellant also appeared but did not testify.

[redacted], Assistant Corporation Counsel, represented Respondent, Macomb County Community Mental Health (CMH or Department). [redacted], Clinical Supervisor, appeared as a witness for Respondent.

ISSUE

Did Respondent properly deny Appellant's request to substitute Community Living Supports (CLS) for nursing 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. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who has been diagnosed with Duchenne's muscular dystrophy, cardiomyopathy, respiratory failure, sleep apnea, osteoporosis, acid reflux, and hypotension. (Exhibit A, pp 36-37; Testimony)

2. Appellant requires total care in all aspects of daily life activities, mobility and feeding. Appellant is ventilator dependent, has a tracheotomy and a g-tube for feeding. Appellant's intellect, reasoning, and understanding are intact. Appellant is his own guardian. (Exhibit A, pp 36-37; Testimony)

3. For the period of [redacted] through [redacted], Appellant was authorized for supports coordination, 209 hours per month of LPN services, 421 hours per month for RN services and 93 hours per month of CLS services. Appellant also receives 141 hours per month of Adult Home Help. (Exhibit A, p 2; Testimony)

4. Appellant has multiple health issues that require nursing attention, including having a tracheotomy, ventilator, and g-tube. Appellant's father is his primary caregiver. Appellant requires frequent suctioning both orally and through his tracheostomy tube. Appellant was hospitalized three times in [redacted] and had at least three respiratory infections in [redacted]. Appellant's health has stabilized in [redacted] since be began receiving all nutrition through his g-tube. Appellant continues to require skilled care and supervision 24/7. (Exhibit A, pp 11-37; Testimony)

5. On [redacted], CMH received a request for 575 units of CLS for the period of [redacted] through [redacted]. The request was for a transfer of hours from nursing services to CLS. (Exhibit A, pp 1-2; Testimony)

6. On [redacted], CMH sent Appellant an Adequate Action Notice informing him that his request for 575 units of CLS, to be transferred from already approved LPN and RN nursing services, was denied. The notice stated: "Staffing convenience does not establish medical necessity for a lower level of care. PDN and CLS are distinctly separate services." (Exhibit A, pp 5-7; Testimony)

7. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit 1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR).

It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides

> eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services. [42 CFR 430.0.]
>
> * * *
>
> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. [42 CFR 430.10.]

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:
    - o that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - o that are experimental or investigational in nature; or
    - o 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
October 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.

Private Duty Nursing (PDN)

Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act,

> consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.
>
> - Community living supports
> - Out-of-home non-vocational habilitation
> - Prevocational or supported employment
>
> To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.
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> *Medicaid Provider Manual*
> *Mental Health/Substance Abuse Chapter*
> *October 1, 2015, pp 96-98; 105*
> Emphasis added

Here, Appellant's request for 575 units of CLS, to be transferred from already approved LPN and RN nursing services, was denied. The Department argued that the denial was proper because CLS and nursing services are two distinctly separate services that cannot be interchanged. The Department pointed out that a CLS worker is not allowed to provide medical care, such as suctioning, nor can a CLS worker take a medical order from a doctor and initiate the care ordered.

Appellant's father testified that while he understands that CLS workers are not allowed to perform suctioning, he is allowed to suction Appellant and he is always present when CLS workers are present. Appellant's father indicated that he was not asking for extra hours, but simply asking to transfer hours from nursing to CLS. Appellant's father testified that such transfers have been granted in the past when circumstances required without any issue. Appellant's father indicated that the present request arose out of a situation where he was unable to obtain nursing staff from the staffing agency because one of Appellant's nurses left for another job and two others were sick, so he did not want them near Appellant. Appellant's father testified that out of necessity, he asked for CLS workers to fill in for the absent nurses and they did so, relying on his assertion that they would be paid for their time. Appellant's father indicated that he did not seek prior authorization for the change because such transfers had been approved in the past.

Appellant's father also indicated that the CLS workers stopped assisting Appellant outside of their assigned hours when the transfer was denied by CMH and that it then took almost two days for the nurse staffing agency to find nursing staff to assist Appellant. Appellant's father testified that during those two days he had to care for Appellant by himself; a dangerous proposition given that Appellant would die if he is not suctioned when his alarm goes off. Appellant's father testified that Appellant is not on death's door, as the CMH seemed to suggest, and that he and the CLS workers were able to take very good care of him when nurses were unavailable.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of the evidence that CMH erred in denying his request for 575 units of CLS, to be transferred from already approved LPN and RN nursing services. Here, Appellant has multiple health issues that require nursing attention, including having a tracheotomy, ventilator, and g-tube. Appellant requires frequent suctioning both orally and through his tracheostomy tube and he was hospitalized three times in [redacted] and had at least three respiratory infections in [redacted]. And, although Appellant's condition stabilized a bit in [redacted], Appellant continues to require skilled care and supervision 24/7. This skilled care can only be provided by a qualified nurse; it cannot be provided by a CLS worker. As such, CLS services cannot be used as a substitute for nursing services, even though Appellant's father is present with the CLS workers.

As indicated above, community living supports are intended to facilitate an individual's independence, productivity, promote inclusion and participation and include services such as meal preparation, household tasks, shopping, self-care, socialization, relationship building, support with money management, non-medical care, and transportation. Private duty nursing, on the other hand, is to provide skilled nursing interventions to meet an individual's health needs that are directly related to his developmental disability. These services are separate and cannot be substituted for each other.

Appellant's father should be commended on the enormous support that he provides to his son. It is very unfortunate that the circumstances arose as they did and left Appellant's father feeling as if he had no choice but to use CLS workers to care for his son. Part of his choice was clearly driven by the fact that CMH has apparently approved such transfers in the past. However, just because CMH may have mistakenly approved transfers of hours in the past, that does not mean that such transfers are allowable under Medicaid policy. Clearly they are not. And, because this ALJ has no equitable powers, he cannot order CMH to allow the transfer this time, even though it might seem like the fair thing to do given that such transfers were approved in the past. CMH's decision is based on competent and material evidence and is supported by the record.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request for 575 units of CLS, to be transferred from already approved LPN and RN nursing services.

IT IS THEREFORE ORDERED that:

Respondent's decision is AFFIRMED.

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

RJM/cg

Date Signed: [redacted]
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.