RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 15-018508
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted], Guardian and sister, appeared on behalf of the Petitioner. [redacted], Stand-By Guardian and brother; [redacted], sister; and [redacted], Owner/Manager of the home Petitioner lives at, appeared as witnesses for Petitioner. [redacted], Quality Improvement Director and Acting Fair Hearings Officer, represented the Respondent, [redacted] Community Mental Health (CMH). [redacted], Director of Programs and Services; [redacted], Case Manager; [redacted], Access Therapist; and [redacted], Supervisor of Case Manager at the time of the determination, appeared as witnesses for the CMH.

During the [redacted], hearing, the CMH's Hearing Summary packet was admitted as marked, Exhibits A-U, and the Petitioner's argument packet was admitted as re-marked, Exhibits 1-4. The hearing record was left open for one day to allow additional documentation to be faxed. These documents were received on [redacted], and included: a copy of the argument read into the record by Petitioner's Guardian; the CMH's [redacted], phone call note that has been admitted as Exhibit V; and a printout of emails between the Department of Health and Human Services and Petitioner's Guardian that has been admitted as Exhibit 5.

ISSUE

Did Respondent properly deny Petitioner's request for additional hours of Community Living Supports (CLS) services through the Habilitation Supports Waiver Program (HSW)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a [redacted] year-old Medicaid beneficiary who lives in an unliscensed home setting. (Exhibit H. p. 1; Exhibit I)

2. Petitioner has been diagnosed with moderate intellectual disabilities, major depressive disorder, schizoaffective disorder, cerebral palsy with significant spasticity, severe osteoporosis, seizure disorder with vagus nerve stimulation, significant tremors, gout, kidney concerns, bowel irregularities, hypothyroidism, high cholesterol, and gastroesophageal reflux disease. (Exhibit B, p. 2; Exhibit M, p. 1)

3. Petitioner receives services through the Home Help Services (HHS) program administered by the Department of Health and Human Services (DHHS). (Uncontested)

4. Petitioner has also been receiving services through the CMH and the HSW including: Supports Coordination, CLS, psychiatric services, and fiscal intermediary services. Petitioner had been receiving 11.25 hours of CLS per day. (Exhibit B, p. 7; Exhibit J)

5. In [redacted], Petitioner's Guardian expressed concerns about Petitioner's CLS hours once one of Petitioner's roommates moves out of the home and whether there will be sufficient staffing with the CLS and HHS hours for the remaining two women in the home. The concerns specifically included Petitioner having 2 staff during awake hours because the only safe way to transfer Petitioner is a two-person transfer. (Exhibits C and D)

6. On [redacted], the Case Manager conducted an assessment regarding Petitioner's needs and services. (Exhibit B, pp. 1-16)

7. On [redacted], the CMH received a copy of Petitioner's HHS authorization from a [redacted], DHHS re-assessment of Petitioner's HHS hours. Petitioner receives 141 hours and 29 minutes per month (about 4.7 hours per day in a 30 day month) of HHS. (Exhibit E, p. 2; Exhibit G)

8. On [redacted], the Access Therapist provided her assessment of recommended CLS hours, specifically 51 15-minute units (12.75 hours) daily. (Exhibit H, pp. 1-2)

9. On [redacted], the Case Manager called Petitioner's Guardian about the re-assessment determination to increase Petitioner's CLS hours from 11.25 hours daily to 12.75 hours daily. (Exhibit J)

10. On [redacted], a Treatment Plan Addendum was completed. (Exhibit K, pp. 1-19)

11. On [redacted], Petitioner's Annual Treatment Plan was completed. Petitioner's Guardian noted that she did not agree with the recommended CLS hours. (Exhibit N, pp. 1-18)

12. On [redacted], an Action Notice and Review Rights was issued to Petitioner's Guardian stating:

> You requested that CLS hours be provided for the entire 24 hour period minus home help hours (which equates to 18.1 CLS hours per day). This request is denied based on section 15.1 of the Medicaid Provider Manual. CLS services will be authorized to provide the supports allowable under the same section. The amount will authorized at the amount of 51 units per day. (Exhibit L, p. 1)

13. On [redacted], an Action Notice and Review Rights was issued to Petitioner's Guardian stating:

> CLS will be authorized at the amount of 51 units per day based on the Person-Centered Plan goals and objectives and according to the supports allowable under the Medicaid Manual Section 15.1. You requested that CLS hours be provided for the entire 24 hours period minus home help hours (which equates to 18.1 CLS hours per day). The services that you requested, but that were denied, are CLS during night hours in the case the consumer gets up at night and/or soils self in bed, and for daytime hours not covered by Home Help due to the consumer's transferring needs. (Exhibit A, p. 1)

14. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Petitioner's behalf in this matter. (Hearing Request)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…
>
> *42 USC 1396n(b)*

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

Petitioner has been receiving her services through the HSW. With respect to the HSW, the Medicaid Provider Manual (MPM) generally 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.
>
> *MPM, October 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, page 96*
> *(Emphasis added)*

Regarding medical necessity, the MPM provides:

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

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

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

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

2.5.B. DETERMINATION CRITERIA

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

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

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

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

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

- Made within federal and state standards for timeliness;

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

- Documented in the individual plan of service.

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

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

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

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

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

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

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

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

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

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

MPM, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 13-14

Moreover, with respect to the specific service of CLS through the HSW, the MPM provides:

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 non-vocational 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.
>
> *MPM, October 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 97-98*

Here, it is undisputed that Petitioner requires CLS. It is only the amount of hours to be authorized that is at issue with the CMH authorizing 12.75 hours per day of CLS and denying Petitioner's Guardian's request for additional hours.

In support of that decision, the CMH's witnesses testified that the 12.75 hours per day of CLS are appropriate according to Petitioner's medical need, the person centered plan CLS goals, and the MPM policy regarding the use of CLS hours under the HSW. For example, regarding transferring, the CMH witnesses confirmed that additional CLS hours for transferring assistance could not be authorized because Petitioner requires full assistance with this activity, not just prompting, reminding, cueing, observing, guiding and/or training. The CMH witnesses also confirmed that CLS hours are authorized based on Petitioner's medical needs and goals, and cannot be based on staffing considerations for Petitioner as well as the other residents of the home. Lastly, the CMH asserted that CLS hours under the HAB waiver can only be authorized during awake hours.

Petitioner's Guardian's testimony indicated there was confusion with the services authorizations. Particularly the [redacted] person centered plan when there was a significantly higher total estimated cost of services and the CLS authorization was changed to units instead of hours. Additionally, Petitioner's Guardian indicated she did not fully understand what occurred when the addendum issued indicating 45 units of CLS instead of 96 units. However, there is no jurisdiction for this ALJ to review those actions because they occurred more than 90 days prior to the [redacted], hearing request. *42 CFR 431.221(d)* directs that the agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

Petitioner's Guardian disagrees with the authorization of only 12.75 hours of CLS daily. It was noted that the service authorizations for all residents of the home are utilized for

staffing and that CLS hours have always been used for overnight care in the past. Petitioner's Guardian noted that Petitioner needs 24 hour supervision and care and cannot attend to her own basic needs. It was noted that the CMH [redacted] Addendum reflects Petitioner's needs for 24 hour supervision. (Exhibit 2) Additionally, the current Person Centered Plan reflects Petitioner's needs for significant assistance with daily activities. (Exhibit N)

The above cited MPM policy does not support considering the staffing based on the combined services hours for all residents of the home when determining the CLS authorization for Petitioner. Rather, the MPM policy directs that medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be authorized.

The MPM policy supports the CMH determination that additional CLS hours could not be authorized for Petitioner for transferring. It is uncontested that Petitioner requires full assistance with this activity, not just prompting, reminding, cueing, observing, guiding and/or training. Petitioner has been authorized one hour and 10 minutes of HHS daily with this activity. (Exhibit G) It was noted that the recent HHS increase was mainly related to transferring Petitioner using the Hoyer lift. (Exhibit H, p. 2) The evidence does not establish that the CMH determined Petitioner's medical needs for assistance with transferring exceed the HHS authorization. Accordingly, no additional CLS hours can be authorized for this activity under the above cited section 15.1 MPM policy.

The above cited MPM policy also does not support the use of CLS hours under the HSW when Petitioner is not awake. The MPM directs that for the HSW, CLS is to facilitate an individual's independence, productivity, and promote inclusion and participation. For example, with regard to activities of daily living, CLS involves assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary. These uses would involve Petitioner being awake. Further, while not available at the time of the determination at issue, even the [redacted] emails between Petitioner's Guardian and MDHHS also indicate that CLS hours under the HSW cannot be used overnight. It was noted that the MPM policy for CLS under the HSW does not include a health and safety piece, which is different than the MPM policy for CLS under B3 services where health and safety is listed as a coverage option. The email from MDHHS suggested that the overnight services could potentially be billed as a B3 services, or that other options be considered, such as a Personal Emergency Response System and appealing the HHS authorization. (Exhibit 5, pp. 1-3) Overall, the evidence does not establish that policy allows for CLS hours to be used overnight under the HSW. However, the CMH should follow up with the alternatives suggested in the email from MDHHS, such as assessing whether there is medical necessity for overnight CLS hours as a B3 service, a Personal Emergency Response System, and the potential of appealing the HHS authorization.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for additional CLS hours. Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet

her burden of proof and that CMH's decision must therefore be affirmed. The services that are authorized appear to be sufficient to meet the needs and goals outlined in Petitioner's current plan of service and appropriate under the MPM policy for CLS under the HSW. The MPM policy does not support the use of CLS hours though the HSW when Petitioner is not awake.

The [redacted], emails were not available at the time of the determination at issue. Accordingly, the CMH must have an opportunity to pursue the options suggested in the emails, such as assessing whether there is medical necessity for overnight CLS hours as a B3 service, a Personal Emergency Response System, and the potential of appealing the HHS authorization. Petitioner may file another timely hearing request if she disagrees with any new actions taken by the CMH or if they fail to act with reasonable promptness of this more recent request to consider services beyond the HSW limitations.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for additional hours of CLS services through the HSW program.

IT IS THEREFORE ORDERED that

The CMH's decision is **AFFIRMED**.

Colleen Lack

CL/cg

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

Petitioner [redacted]

DHHS Department Rep. [redacted]