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: February 29, 2016
MAHS Docket No.: 15-021649
Agency No.: [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, an in-person hearing was held on [redacted]. [redacted], Petitioner's father and standby Guardian; and [redacted], Petitioner's mother and Plenary Guardian, represented Petitioner. Petitioner was present for a few minutes at the beginning of the hearing proceedings. [redacted], Hearing Officer, represented the Respondent [redacted]. [redacted], Service Supervisor for Developmentally Disabled and Intellectually Disabled Adults and Children; and [redacted], Manager for Persons with Developmental Disability and Intellectual Disability, appeared as witnesses for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for additional hours of Community Living Supports (CLS) 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. Petitioner is a [redacted] year-old Medicaid beneficiary who lives with his parents. (Exhibit 2, p. 1)

2. Petitioner has been diagnosed with pica, profound mental retardation, seizure disorder and mild cerebral palsy. (Exhibit 2, p. 10)

3. Through the Home Help Services (HHS) program administered by the Department of Health and Human Services (DHHS), Petitioner receives 130.75 hours per month (about 32 hours per week) of HHS. (Testimony)

4. Petitioner has also been receiving services through HBH. Last year, these services included 21 hours of CLS. (Testimony)

5. Petitioner's most recent person-centered planning meeting with [redacted], on [redacted] was for the time period of [redacted] through [redacted] (Exhibit 1, p. 1)

6. During that meeting, Petitioner's parents requested an increase in the CLS hours, which was not authorized. (Exhibit 1, pp. 2 and 11)

7. Goals identified in Petitioner's plan relating to CLS being necessary to provide a consistent structure for Petitioner and for Petitioner to be able to continue residing in the family home with supports over the next year included: Petitioner accepting assistance with personal care and ADLs as needed during time with direct care staff; Petitioner having direct line of sight supervision for health and safety during awake hours with direct care staff; Petitioner having opportunities to participate in a wide range of sensory and motor activities in order to promote retention of fine and gross motor skills as well as attain sensory input needs; and Petitioner having opportunities for community inclusion/integration, peer interaction, and recreational activities for as much as he will tolerate through [redacted] (Exhibit 1, pp. 3-6)

8. Goals identified in Petitioner's plan relating to respite to maintain Petitioner in the least restrictive environment possible with the necessary supports included: Petitioner's parents being authorized 256 hours of respite care to allow them a temporary break from caregiving. (Exhibit 1, pp. 6-7)

9. In support of those goals, Petitioner's authorized services through the Habilitation Supports Waiver included: 5 hours of supports coordination per year, 21 hours per week of CLS, and 256 hours respite per year. (Exhibit 1, pp. 3-14)

10. The Service Supervisor's electronic signature on the plan of service was dated [redacted]. The Notice and Hearing Rights would have been attached to the plan of service. (Exhibit 1, pp. 13 and 15)

11. 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).

With respect to CLS through the Habilitation Supports Waiver, the Medicaid Provider Manual (MPM) provides:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
> - shopping for food and other necessities of daily living
>
> CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under

the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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 appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS 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 non-medical 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 coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS 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.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living 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 the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

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, July 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 122-123*

However, while CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the MPM also 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, July 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 13-14

Here, it is undisputed that Petitioner requires CLS. It is only the amount of hours to be authorized that is at issue, with HBH authorizing 21 hours per week of CLS and denying Petitioner's request for additional hours.

In support of that decision, the HBH witnesses testified that the authorized hours are sufficient to meet the goals in Petitioner's plan. The testimony indicated that Petitioner used to get more CLS hours in the past, but HBH believed that at that time Petitioner was receiving less HHS hours through DHHS. The HBH witnesses acknowledged that Petitioner's parents have reported that Petitioner regressed. However, the HBH witnesses noted that the parents' reports of regression have not been supported. For example talking with staff and reviewing documentation did not show a change in level of function or level of need for care and supports. It was noted that HBH had asked Petitioner's parents to start documenting more so there would be a baseline and to show when there are changes. However, there were only a few entries and not much to support a decline in function of change in needs. HBH asserts that the 21 hours per week of CLS, along with 256 hours per year of respite, are the appropriate medically necessary level of services.

In response, Petitioner's father asserts that there has been regression. Petitioner's father also noted that the CLS staff are only there a small portion of the week; 21 hours. Accordingly, Petitioner's father testified that the CLS staff does not have the full picture. Petitioner's father indicated that as the parents, they see more. Petitioner's father provided documentation from [redacted] through [redacted] For example, it was noted that Petitioner's score on the Northcare Network Functional Assessment for Persons with Intellectual/Developmental Disabilities has been increasing: 30.5 on [redacted]; 31.5 on [redacted] 41 on [redacted]; and 63 on [redacted]. (Exhibit A, p. 2; Exhibit B, pp. 17-24; Exhibit C, pp. 18-25; Exhibit D, pp. 1-8; and Exhibit E, pp. 19-26) Petitioner's father also noted that when [redacted] first proposed the reduction to Petitioner's CLS hours, a prior Administrative Hearing Decision and Order reversed the HBH determination on [redacted]. Then when a reduction was proposed again, it was upheld by another Administrative Hearing Decision and Order on [redacted] (See Exhibit A, p. 1) Petitioner's mother concurred that Petitioner is needing more care all the time.

It is understood that the CLS staff is present a far smaller portion of the week than Petitioner's parents. However, it would be expected that significant regression, and/or any changes in level of function/needs would be noted by other sources, not just by Petitioner's parents. For example, these types of changes would also be expected to be observed by CLS staff, who regularly assist Petitioner on an ongoing basis. Accordingly, the testimony of the HBH witnesses indicates that HBH properly sought information form other sources, such as the CLS staff and any documentation in Petitioner's case record, to find support for the reports from Petitioner's parents.

Regarding the score increases, it is noted that the [redacted], Northcare Network Functional Assessment for Persons with Intellectual/Developmental Disabilities form, with the score of 63, is the only one that was completed by Petitioner's parents. (Exhibit B, pp. 17-24; Exhibit C, pp. 18-25; Exhibit D, pp. 1-8; and Exhibit E, pp. 19-26) It is also noted that over this same timeframe Petitioner's Axis V GAS score, when available, has remained fairly stable: 20 on [redacted] 21 on [redacted]; and 21 on [redacted]. (Exhibit B, p. 9; Exhibit C, p. 9; Exhibit E, p. 10)

This ALJ also reviewed the prior Administrative Hearing Decisions and Orders referenced by Petitioner's father. The [redacted] Administrative Hearing Decision and Order, MAHS Docket No. 2013-55096, reversing the proposed CLS reduction was based on improper notice of the proposed reduction and HBH failing to identify or delineate the services at issue. It appears that at that time, HBH had merged the CLS and HHS hours to such an extent that it could not clarify the amount of the current HHS and the amount of CLS that was at issue. Accordingly, this reversal was not based on any determinations of what CLS hours were medically necessary or sufficient in amount, scope, and duration to meet their purpose. The [redacted], Administrative Hearing Decision and Order, MAHS Docket No. 2014-15174, upheld the HBH determination that 21 hours of CLS per week, along with the weekly HHS hours, were sufficient to meet Petitioner's needs.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for additional CLS hours. The services that are authorized appear to be sufficient to meet the needs and goals outlined in Petitioner's current plan of service. Petitioner has already been authorized a significant amount of CLS, in addition to the respite care and HHS, and he possesses the flexibility to use it as needed. There was insufficient evidence to support the reports from Petitioner's parents regarding regression or to establish any changes in Petitioner's level of functioning or level of needs for care and supports at the time of this determination. Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that HBH's decision must therefore be affirmed.

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.

IT IS THEREFORE ORDERED that

The Department'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

Petitioner [redacted]

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS Department Rep. [redacted]

DHHS-Location Contact [redacted]