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:

Docket No. 15-015529-CMH

[redacted] [redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted] [redacted] Advocate, Authorized Hearing Representative, appeared on Appellant's behalf. [redacted] [redacted] Appellant's sister and power of attorney, appeared as a witness.

Attorneys [redacted] and [redacted], represented [redacted], the mental health authority for [redacted] (CMH or [redacted] [redacted] Utilization Review Specialist; [redacted] Fair Hearings Officer; [redacted] Utilization Management Program Manager; and [redacted] Contract Manager, appeared as witnesses for the CMH.

ISSUE

Did the CMH properly calculate 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. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted] who is diagnosed with Unspecified Mental Retardation, Down's Syndrome, Brain Neoplasm NOS (Brain Tumor), and Problems related to Social Environment. (Exhibit D, pp 1, 5; Testimony).

2. [redacted] is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony)

3. Appellant lives with his parents and younger brother in a single family home in [redacted]. (Exhibit D, p 2; Testimony).

4. Appellant's natural supports consist of his parents, two brothers and two sisters. Appellant's parents and sister are his durable power of attorney. Appellant's parents are his representative payee. (Exhibit D, pp 3, 7; Testimony)

5. Appellant's adaptive functioning is significantly delayed but he can show relative strength in functional academics, school living, community use and leisure. Appellant can get to and from school independently, and use small electronic equipment and computers independently. Appellant needs assistance with self-direction. (Exhibit D, p 3; Testimony)

6. Appellant has attended [redacted] school system since [redacted] where he has participated in both special education and general education courses. (Exhibit D, p 4; Testimony)

7. As part of the Person Centered Planning (PCP) process, Appellant's Supports Coordinator met with Appellant and his family for a pre-planning meeting, met with Appellant and his family for a PCP meeting, and completed a Social Work Assessment in preparation for service planning for the upcoming year. (Exhibit D; Testimony)

8. Also as part of the PCP process, Appellant's Supports Coordinator completed a B3/CLS Support Needs Worksheet on [redacted] in order to determine how many [redacted] minute units of CLS Appellant would need each week. Through this process, Appellant's Supports Coordinator recommended that [redacted] minute units of CLS per week be authorized. (Exhibit E, p 2; Testimony)

9. The Supports Coordinator's recommendation and supporting documentation was reviewed by a Utilization Review Specialist at [redacted], who determined that only [redacted] minute units of CLS were medically necessary for Appellant based on the submitted documentation. Specifically, [redacted]'s Utilization Review Specialist removed [redacted] recommended CLS units for shopping because there was no documentation in the assessment regarding Appellant's needs for CLS in the area of shopping and removed [redacted] recommended CLS units for money management/buying goods because the assessment indicated that Appellant is able to determine if he has enough money to pay for things because he can count bills and round up amounts, and because Appellant has a representative payee to handle his other finances. (Exhibit G; Testimony)

10. On [redacted] sent Appellant a Notice of Action indicating that his request [redacted] minute units of CLS per week was denied as not medically necessary, but that [redacted] minute units of CLS per week were authorized. (Exhibit F; Testimony)

11. Appellant's Exhibit 9 is a memo from MDHHS indicating, in part, that screening tools cannot be used as "an arbitrary means for identifying the amount, scope or duration of services that an individual will receive. While such assessments can certainly inform the person-centered planning process, it is the person-centered planning process and medical necessity criteria that determine the amount, scope and duration of services." (Exhibit 9; Testimony)

12. On [redacted] Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (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*

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. BABHA contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The *Medicaid Provider Manual (MPM), Mental Health/Substance Abuse,* section 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 13-14

The MPM states with regard to community living supports:

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community

inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:

  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator **must** request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and nonmedical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. (Underline emphasis added by ALJ).

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
July 1, 2015, pp 122-123

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need for beneficiaries:

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service. (Emphasis added).

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
July 1, 2015, p 120

CMH's Contract Manager testified that she works with the Division of CMH that works with the developmentally disabled (DD) population and specifically with persons such as Appellant who utilize self-determination. CMH's Contract Manager indicated that she has been in her current position for [redacted] years and has worked with the DD community for more than [redacted] years. CMH's Contract Manager testified that [redacted] manages Medicaid funds distributed by the federal government through the states for beneficiaries who reside in the service area. CMH's Contract Manager reviewed the CMH's annual budget for persons with developmental disabilities and indicated that if the CMH were found to be distributing those monies contrary to federal regulations and state policy, the CMH would have to pay that money back. CMH's Contract Manager reviewed the above policy from the MPM relating to CLS, B3 services, and medical necessity. CMH's Contract Manager indicated that while the MPM gives a broad definition of what constitutes medical necessity, it is up to the CMH to figure out how that applies to the clients it serves. CMH's Contract Manager discussed how the CLS Worksheet was developed and how supports coordinators were trained on the use of the Worksheet. CMH's Contract Manager indicated that the Worksheet does contain a cap, or maximum amount of CLS that can be authorized, but indicated that if a person needs more than that amount exceptions can be made or they can be transitioned to a daily level of care, which would amount to more CLS than that found in the Worksheet.

CMH's Contract Manager reviewed Appellant's Exhibit 9, which is a memo from the Department indicating, in part, that screening tools cannot be used as "an arbitrary means for identifying the amount, scope or duration of services that an individual will receive. While such assessments can certainly inform the person-centered planning process, it is the person-centered planning process and medical necessity criteria that determine the amount, scope and duration of services." CMH's Contract Manager testified that the memo was not issued in response to [redacted] B3/CLS Worksheet, but rather a region-wide worksheet that had been introduced and used for a short period of time before being discarded.

CMH's Utilization Review Specialist reviewed [redacted] person-centered plan (PCP) process, which includes meetings with beneficiaries and their families, the review of documents, the completion of assessments, and takes approximately [redacted] months in most cases. CMH's Utilization Review Specialist indicated that requests for services, including CLS, are then sent to the Utilization Management (UM) team at [redacted] for review and authorization. CMH's Utilization Review Specialist pointed out that the authority for UM is found in the MPM at Section 2.5.D. CMH's Utilization Review Specialist testified that in conducting a UM review, she first checks to make sure all documents are present and then compares the documents side-by-side with the authorization requests to ensure that all requests are supported in the documentation. CMH's Utilization Review Specialist indicated that budget plays no role in UM and she is unaware of the CMH's budget when she conducts a UM review. CMH's Utilization Review Specialist indicated that she has both increased CLS authorization requests and decreased those requests in UM reviews she has done. CMH's Utilization Review Specialist indicated that UM started at [redacted] about t[redacted] years ago and that she has been in her current position for about seven months. CMH's Utilization Review Specialist indicated that she has worked with the DD community for over 1[redacted] years as both a supports coordinator and a supports coordinator supervisor.

CMH's Utilization Review Specialist reviewed Appellant's UM review, which is found in Exhibit G. CMH's Utilization Review Specialist indicated that she removed [redacted] recommended CLS units for shopping because there was no documentation in the assessment regarding Appellant's needs for CLS in the area of shopping. CMH's Utilization Review Specialist also testified that she removed [redacted] recommended CLS units for money management/buying goods because the assessment indicated that Appellant is able to determine if he has enough money to pay for things because he can count bills and round up amounts, and because Appellant has a representative payee to handle his other finances. CMH's Utilization Review Specialist reviewed the Notice of Action found in Exhibit 3 and indicated that the supplemental form, which is found in Exhibit G and explains the denial in more detail, went to Appellant's supports coordinator, who would be responsible for explaining the denial in more detail to Appellant and his family. CMH's Utilization Review Specialist testified that because Appellant uses self-determination, his supports coordinator is actually employed directly by him and his family.

Appellant's sister testified that Appellant has Down's syndrome. Appellant's sister indicated that Appellant is very sweet, but shy and has difficulty expressing himself, especially in cases of emergency. Appellant's sister indicated that prior to the recent cuts in his CLS, Appellant was using all of his CLS hours and needs those hours to meet the goals in his plan. Appellant's sister indicated that the cuts basically remove an entire day of CLS activities from Appellant's schedule. Appellant's sister testified that Appellant goes to a youth group, volunteers at local restaurants, and loves to go to the library. Appellant's sister indicated that because Appellant cannot advocate for himself, he needs CLS staff to accompany him during most of these outings. Appellant's sister testified that Appellant can carry money and figure out how much money he needs to pay for things, but has to trust that the person giving him change is giving him the right amount. Appellant's sister described an incident with a vending machine where Appellant could not figure out how to request change, so he continued to purchase items until all of his money was used up. Appellant's sister indicated that Appellant does need help with using money in the community. Appellant's sister also indicated that CLS staff go shopping with Appellant, help him with money management on shopping trips, which makes him more independent in the community. Appellant's sister testified that Appellant has always been working on these goals, even though they may not have showed up in his Individualized Plan of Service (IPOS) this time around. Appellant's sister testified that Appellant also goes shopping with his mother and enjoys cooking, but needs assistance figuring out what to buy for any particular recipe. Appellant's sister also indicated that Appellant has dietary needs and sometimes needs assistance in determining what he can and cannot eat. Appellant's sister testified that Appellant will advocate for something if he wants it, but will shut down in emergency situations. Appellant's sister testified that she was involved in the most recent PCP process and agreed that the process was a collaborative one. Appellant's sister also testified that she understood that [redacted] was not responsible for ensuring that Appellant's plan is complete and acknowledged that Appellant has met goals in the past and his plans have changed over the years.

Based on the evidence presented, it is determined that Respondent's process for determining CLS services is proper and in conformance with federal regulations and policy. The clinician who completed the utilization review of the recommendation made by Appellant's Supports Coordinator took into account Appellant's needs and the specific, individual goals in his IPOS.

The person-centered planning process was followed correctly and was a collaborative process between Appellant, his family, and his supports coordinator. Unfortunately, it appears that Appellant's supports coordinator, who is employed by Appellant and his family, failed to include documentation and justification for the use of CLS for money management and shopping in the plan. While these goals may have previously appeared in Appellant's plan, they did not appear clearly in this plan and [redacted] was correct in reducing Appellant's CLS accordingly.

Furthermore, Appellant's argument that the Notice given to Appellant was inadequate because it did not indicate specifically why Appellant's CLS was reduced is without merit. The Notice indicated that Appellant's CLS was reduced due to a lack of medical necessity, as required by policy and federal regulations. [redacted] also went one step further by sending a supplemental sheet to Appellant's supports coordinator, which clearly and specifically showed why Appellant's CLS was reduced. At that point, it would have been up to the supports coordinator to inform and educate Appellant's family regarding the reduction and discuss the best options for trying to have the CLS hours reinstated. It does not appear that that happened here. [redacted] can only base its decisions on the information provided to it and in this case, that decision was supported by the evidence in the record.

Ultimately, [redacted] has a mandate to allocate the limited funds it receives from the [redacted] to provide services to all eligible persons in its service area and the CLS process used here, including person-centered planning, the CLS worksheet, and utilization management, is an acceptable and authorized method for meeting that mandate. The CLS Worksheet is but one tool used in the process and is in no way used in an arbitrary way to identify the amount, scope and duration of services. As indicated above, "The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports."

Appellant bears the burden of proving by a preponderance of the evidence that the reduction in his CLS services was improper. Based on the foregoing analysis, Appellant has failed to meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly calculated Appellant's CLS services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

Date Signed: [redacted]

Date Mailed: [redacted]

RJM/db

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.