RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 6, 2016
MAHS Docket No.: 16-004928
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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]. Attorney [redacted] ([redacted]) represented Petitioner. Petitioner's father and Guardian [redacted] appeared and testified on behalf Petitioner. Petitioner Hannah Ernst did not appear at the hearing. [redacted], Fair Hearings Officer; [redacted], Program Administrator and [redacted], Service Utilization Manager represented the [redacted] County Community Mental Health (CMH or State or Department).

State's Exhibits 1-6 and Petitioner's Exhibits A-I were admitted as evidence.

ISSUE

Did the CMH properly determine that Petitioner's request for increased Community Living Supports (CLS) hours should be denied?

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 Medicaid beneficiary, date of birth [redacted].

2. Petitioner has a diagnosis of Angelman's Syndrome with regular seizures and difficulty eating. She is unable to perform Activities of Daily Living. She has extremely limited nonverbal communication. She requires 24/7 support, which can be in a shared environment. (State's Exhibit 1 page 1)

3. Petitioner currently resides with her family and receives 70 hours per week in CLS.

4. Petitioner's Guardians have had ongoing conversations with CMH staff about moving Petitioner to an independent living setting where CLS services will need to continue to be provided.

5. On [redacted], [redacted] CMH ([redacted]CMH) received a formal request form Petitioner's Guardian for 24/7 one on one CLS staffing beginning when the beneficiary moves into independent living. (State's Exhibit 1)

6. The request was forwarded to [redacted]CMH Utilization Management (UM) Department of review.

7. On [redacted], M staff found that additional information was needed, including a new CLS assessment, before a decision could be made regarding the CLS request. (State's Exhibit 2)

8. On [redacted], [redacted]CMH sent a delay notice to the beneficiary stating that the delay was made for the following reasons: Decision is being delayed on Community Living supports (CLS) while Home Help application is completed, CLS assessment is completed and while family continues to explore roommate options. (State's Exhibit 3 page 1)

9. On [redacted], the CLS assessment was completed and information was forwarded to the UM Department for review.

10. On [redacted], the UM Department denied the request for 24/7 one on one CLS staffing, finding that there was not enough additional information form the family so that another UM review could occur. (State's Exhibit 5)

11. On [redacted], a denial notice was sent to the beneficiary, requesting additional information from the family so that another: i.e. documentation of needs during overnight hours and documentation and additional information regarding your proposed future residence. (State's Exhibit 5 page 1)

12. On [redacted], The Michigan Administrative Hearing system received a Request for Hearing from Petitioner about the denial of increased CLS hours.

13. On [redacted], The Michigan Administrative Hearing system received a Request for Hearing from Petitioner about the delay in the decision making of [redacted]CMH as they wanted to move Petitioner into her new living space by [redacted].

14. On [redacted], [redacted] CMH UM received additional information related to the beneficiary's needs and will be providing a decision, along with notice and hearing rights within 14 days ([redacted]).

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).

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.*

CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve his/her goals.

The Medicaid Provider Manual (MPM) Provides direction for Services for Developmentally disabled individuals:

> **2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES**
>
> Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:
>
> - Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
>
> - Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.

- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).

- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES states:

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

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. MDHHS 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.

The *Medicaid Provider Manual* articulates Medicaid policy for Michigan. Its states with regard to community living supports:

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. (Emphasis Added)

- 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.

Behavioral Health and Intellectual and Developmental Disability Supports and Services, Date: April 1, 2016, pages 122-123

Petitioner currently receives 70 hours per day of CLS while she is living with her parents. She is [redacted] years old. She attends school. 160 hours per week (24 hour coverage) of CLS is what Petitioner is requesting. However, the Medicaid Provider Manual clearly outlines the extent to which CLS services may be granted. Medicaid policy clearly states that CLS services may not supplant services otherwise available, e.g. Personal Care Services or home Help Services. CLS is not meant to be a 24 hour service and is not mean to meet all of Petitioner's needs. MPM policy indicates that 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 DHHS'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.

CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Petitioner's request for 24 hour care (160) hours per week in Community Living Support service hours must be denied. Based on Petitioner's current Individual Plan of Service (IPOS), 70 hours of CLS per week, in conjunction with other approved services is sufficient in amount, scope and duration to meet Petitioner's medically necessary needs.

This Administrative Law Judge finds that the evidence on the record does not indicate that the CMH has determined that Petitioner needs less than 24 hour care. On the contrary, CMH has recognized that Petitioner's move to independent living will require substantial coordinated services. CMH is not required to move according to Petitioner's schedule but must make the most appropriate decision with the information provided to it. CMH has correctly determined that the care cannot be provided through CLS hours solely, but must be provided through coordinated care of CLS hours, Home Help Services, Expanded Home Help Services, School, natural supports and other services potentially available to Petitioner. Coordination of the services is complicated and time consuming, but there is no requirement in policy that mandates the CMH to provide (24 hours) 160 hours per week of care through CLS when other potential resources are available and must be explored.

WCCMH's decision to delay the request for more information and to deny the request for insufficient information must be upheld as all resources for Petitioner's support in independent living have not been properly explored.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized CLS in an amount that is sufficient in scope and duration under the circumstances.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

LL/[redacted]

Landis Lain
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]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]

DHHS Department Rep. [redacted]

Counsel for Petitioner [redacted]