RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: July 26, 2016
MAHS Docket No.: 16-003335
Agency No.:
Petitioner:

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, an in-person hearing was held on July 21, 2016. , American Sign Language Interpreter, appeared to interpret from Interpreter Network. Attorney (P) represented Petitioner. Authorized Hearing Representative , Petitioner , , Dr. , , , appeared to testify on behalf of the Petitioner.

Attorney (P) represented the Community Mental Health for Central Michigan (CMHCM or Respondent or Department or State). , Utilization Manager appeared to testify on behalf of the MCCMH.

Exhibits stipulated to for admission: Petitioner's Exhibits 1-8 and Respondent's Exhibits 1-13

ISSUE

Whether CMHCM properly proposed to cancel Petitioner's overnight Community Living Supports?

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 who is currently enrolled in the Home and Community Based Waiver, and is currently receiving Medicaid Covered Community Living Supports (CLS).

2. Petitioner lives independently in the community.

3. Petitioner was receiving 224 units per week of overnight CLS hours.

4. Petitioner is employed at VOICE 15-18 hours per week and receives Social Security Income. He performs janitorial work. Petitioner needs job coaching at any job in the community. CMHCM funds job coaching. (Respondent's Exhibit 8, page 154)

5. The February 29, 2016 Psychosocial Assessment for Petitioner indicates that Petitioner needs assistance with transportation, community safety, health and medical safety, financial exploitation, home environment and fire safety, specifically Petitioner needs supports in place for night time safety, and has special equipment to assist in that. (Respondent's Exhibit 8, page 155)

6. Petitioner is deaf (non-speaking) and uses sign to communicate. He needs assistance with most Activities of Daily Living (ADLs). He has good receptive and expressive language skills and is diagnosed with developmental disability in the form of communication disorder, organic brain syndrome, moderate cognitive impairment, learning disabled, physical impairment. Petitioner has Obsessive Compulsive Disorder and becomes anxious. He will eat until he becomes sick and requires portion control of meals and snacks. (Respondent's Exhibit 8, pages 147-148)

7. Petitioner has major mental illness diagnosis of: Schizophrenia, anxiety disorder NOS, Intermittent explosive disorder, mild intellectual disabilities, with an Axis V GAF of 40 (12/1/2014). (Respondent's Exhibit 8 page 167)

8. Petitioner needs physical assistance with medication administration, laundry, cooking, transportation, housecleaning, paying bills, leisure/recreation and community access. He needs verbal prompting for dressing. He is independent in toileting, eating, transferring and ambulation and bathing. (Respondent's Exhibit 8 page 156)

9. On March 9, 2016, in a CLS Committee Review form, CMHCM determined that Petitioner would no longer be approved for Requested H2015 overnight Units, but would retain receipt of 262 units of H2015 1:1 units of CLS care. (Respondent's Exhibit 5, page 22)

10. On March 16, 2016, CMHCM sent Petitioner an Action Notice and Hearing Rights form which stated that Petitioner's request for overnight staffing (H2015 0) were denied because documentation does not establish medical necessity. (Respondent's Exhibit , page 9)

11. On March 29, 2016, Petitioner's Representative filed a request for hearing to contest the denial of overnight staffing stating: "We did not have the opportunity to review this page at the meeting (3/16/16) and did not check the boxes. We said at the time that we would appeal the action recommended – i.e. to eliminate night staff. And, of course, we didn't sign the agreement piece below. Also, the materials were sent to Matthew's house and received no attention until it occurred to us that might have been why we didn't receive the action, form and envelope."

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).

CMHCM is mandated by federal regulation to perform an assessment for the Petitioner 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 Petitioner's goals. CMHCM is required to use a person centered planning process to identify medically necessary services and how those meets will be met.

The Michigan Mental Health Code explicitly states:

> **330.1712 Individualized written plan of services.**
>
> Sec. 712.
>
> (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.

The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

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.*

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.

Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and

Services, July 1, 2016, Page 13

CMH is mandated by federal regulation to perform an assessment for the Petitioner 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.

MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Date: April 1, 2016, Page 8

The *Medicaid Provider Manual* articulates Medicaid policy for Michigan. It states:

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed

through the person-centered planning process. HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 Waiver Supports and Services.

Community Living Supports (CLS)

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home 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 MDHHS 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.

Behavioral Health and Intellectual and
Developmental Disability Supports and Services,
Date: April 1, 2016, pages 102

In the instant case, CMHCM determined that based on CLS Committee Review, "…*this consumer's 1:1 H2015 hours are being approved at the previously requested rate of 262 units/week (65.5 hours per week). In addition, the consumer will be receiving 49 hours per month of AHH services (196 units/month). In total, between CLS and AHH this consumer will be approved for 75.75 hours/week of service. The consumer did request continuation of 56 hours of overnight CLS staffing; after reviewing the overnight logs as well as seeing this consumer's level of functioning in communicating with PERS during the day via TTY it was decided that this consumer does not have significant interventions being performed at night that would necessitate medical necessity of receiving overnight CLS staffing. At this time the consumer should be titrated down from his overnight staffing to 0 units after a month*…" (Respondent's Exhibit 5 pages 22-23)

Petitioner alleges that he is entitled to overnight CLS services under the following criteria:

> 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.

Petitioner asserts that he cannot remain in his home in a safe and healthy manner without overnight CLS hours. His safety and health are monitored while he is asleep and when he is awake.

Petitioner's Representative argues that Petitioner has received services for over six years. A disruption of those services and a deviation from the Plan of Service will be detrimental to him. Petitioner's Representative further argues that the appropriate protocol was not followed to determine the amount of CLS hours needed based upon medical necessity. Lastly, the Petitioner's Representative argues that the service agency's request for an increase in CLS services should not have resulted in a reduction of services for an individual who is both Medicaid and functionally eligible for those services. The problem is with the provider's billing and documentation process. The Petitioner should not be penalized for the billing errors of the service provider.

The Medicaid Provider Manual explicitly states:

> 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.

The Person Centered Plan indicates that barriers that might need to be considered are: Safety of Petitioner being home alone at night is a concern of Petitioner, his mother and his staff. They are concerned that he will not sleep if home alone and will roam outside. Also there is concerns about his safety in the event of a fire, natural disaster or a break in. further reduction in staffing or other services – not recommended. (PCP Page 2 of 7, Petitioner's Exhibit 1 page 002)

Petitioner had a roommate until 2010. He went without night staffing for about five or six months. During that time he began to have increased problems with insomnia, which was likely organic and partially behaviorally induced. He was noted to be fearful of nightmares when alone and would avoid sleep. He also felt frightened to sleep when alone and avoided sleep for those reasons too. He developed increased anxiety, increased (preservations) and renewed thought disorders and psychotic symptoms, despite medical management. Night staff were re-introduced and Petitioner was able to return to his baseline. He has had night staff and day staff since those incidents in 2010.

Petitioner wakes in the night and sometimes has stool accidents. He is fearful and solves his problems by speaking with his night staff. They are instrumental in helping clean up stool accidents as Petitioner is unable to manage clean up independently. If he had no night staff he would call CST and they would have to come over each night after a nightmare.

Evidence on the record indicates that Petitioner needs substantial assistance during the day to maintain his current level of functioning. He is unable to work unassisted and needs assistance with most activities of daily life. He is unable to make decisions and

respond appropriately to emergencies, has difficulty accepting change in his environment, and has emotional reactivity to emergencies that further impairs his problem solving. Petitioner has stressed gait, poor balance and ungainly postural control. Petitioner requires that staff be able to communicate with him appropriately via [redacted] Sign Language to calm him and de-escalate.

This Administrative Law Judge finds that the record is replete with indications that Petitioner cannot function appropriately without substantial supervision. CMHCM failed to provide any information or evidence (beyond the bald statement that CLS should not be provided while a person is sleeping) that it assessed Petitioner as safe without his night time staff. Nor was there any documentation provided which would establish Petitioner's safety if he were without overnight CLS. Petitioner has not mastered a safety plan for the daytime and has definitely not mastered a safety plan for the night time. He appears to lack the cognitive skills to engage in problem solving during regular activities and thus, would also lack such skills during an emergency or an unexpected situation. He must be redirected for routine tasks. Moreover, Petitioner can only communicate through sign language. He requires redirection during the day's activities. He also requires redirection at night when he awakens to return to sleep. Petitioner has a known pattern of deterioration – behaviorally, emotionally and psychiatrically – when he is left alone at night. There was no change in the day time CLS hours, which would indicate that Petitioner's medical condition remains static. Nor was there any argument by CMHCM that Petitioner's condition has improved/changed such that he no longer needs supervision or safety attendants during the day or at night. Petitioner has not failed the test for medical necessity eligibility for personal CLS services. There has been no evidence provided to this Administrative Law Judge that Petitioner's medical condition has improved or that the diagnoses have changed since the implementation of the Person Centered Plan from 2010 forward. Petitioner is still deaf. He still has organic brain syndrome. He still needs redirection for tasks. He requires assistance to work and participate in community activities at his placement level.

Finally, the Department failed to cite a policy, rule or law which allows the Department to disregard or circumvent the Person Centered Planning process when making a determination for eligibility for Community Living Services.

CMHCM has not 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 overnight Community Living Service hours should be reduced/cancelled based upon the Department's utilization unit's assessment. The Department's decision cannot be upheld under these circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMHCM did not properly reduce/cancel Petitioner's overnight CLS hours under the circumstances.

IT IS THEREFORE ORDERED that:

The CMHCM decision is **REVERSED**. The Department is **ORDERED** to reinstate Petitioner's Community Living Services to the prior approved level as determined by the Person Centered Planning Process.

LL/

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

DHHS -Dept Contact

Counsel for Petitioner

Petitioner

Counsel for Respondent

DHHS Department Rep.

DHHS-Location Contact

Authorized Hearing Rep.