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: December 21, 2016
MAHS Docket No.: 16-010675
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

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 telephone conference hearing was held on 11/17/16. [redacted], Petitioner's sister and legal guardian, appeared and testified on behalf of the Petitioner. [redacted], Petitioner's sister and caregiver, also testified as witness for Petitioner. [redacted], Supports Coordinator at CMH of [redacted] County testified on behalf of Petitioner. Petitioner himself was present, but did not participate.

[redacted], Assistant Corporation Counsel, represented the Respondent [redacted] County Community Mental Health. [redacted], Access Manager, testified on behalf of Respondent.

ISSUE

Did Respondent properly reduce Petitioner's Community Living Supports (CLS) and properly act on petitioner request for additional CLS holiday hours?

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 fifty-two-year-old Medicaid beneficiary who has been diagnosed with obsessive compulsive disorder and severe intellectual disabilities. (Exhibit A, page 21).

2. Petitioner has been receiving services through Respondent since 2012, including CLS, skill-building services and supports coordination. (Exhibit A; Testimony of Respondent's witness).

3. Petitioner has been receiving Home Help Services (HHS) through the Department of Health and Human Services (Department). (Testimony of Respondent's witness).

4. Currently, Petitioner receives 16.7 hours per week of HHS. (Exhibit A.2; Testimony of Respondent's witness).

5. In his previous Individual Plan of Service (IPOS), Petitioner was approved for 47 hours per week of CLS and 27.5 hours per week of skill-building services. (Exhibit A.2).

6. On 10/9/15 an Annual Assessment of Petitioner's needs and services was conducted. (Exhibit A, 12-25).

7. During that assessment, it was noted that Petitioner continues to have substantial limitations in the areas of self-care, learning, self-direction, capacity for independent living, mobility, and economic self-sufficiency. (Exhibit A.12-25.).

8. The assessment also found that Petitioner continues to require constant care and supervision, as well as assistance with things such as meal preparation, shopping, finances, utilizing community resources, laundry, medications, toileting, bathing and dressing. (Exhibit A).

9. On 11/19/15, during the development of his person-centered plan for the time period of December 1, 2015 through May 31, 2016, Petitioner requested that his services continue at the CLS hours of 62 hours per week and 5 per day of skill-building. On November 23, 2015, Respondent sent Petitioner written notice that his request for CLS was partially denied and that only 45.5 hours per week of CLS services would be approved. Petitioner subsequently requested an appeal, and on 3/8/16 ALJ Kibit issued a Decision and Order upholding the reduction to 45.4 hours per week of CLS hours. (Docket No: 15-023085).

10. On 5/10/16, pursuant to a review, including the annual review in 10/2015 and a PCP Meeting on 5/9/16, Petitioner requested authorization for 47 or more CLS hours. Petitioner also request an additional 22 hours (or 88 units) for Holidays during the next 6 months, including 4th of July, Labor Day, and 2 days for Thanksgiving. (Exhibit A.6).

11. From 11/24/15 through 11/30/15 Petitioner underutilized the approved hours. (Exhibit A.9).

12. On 5/22/16, the Respondent issued an Advance Negative Action Notice informing Petitioner that the 5/10/16 request effective 5/22/16 was approved at 2196 unit for the year. Testimony by the Respondent was that this represents a reduction from 47 to 21 hours per week in CLS hours for the reason: "…CLS is not intended to meet all needs. Approved amount of CLS is sufficient to meet CLS goal of productivity and community inclusion." (Exhibit A.6).

13. The Respondent failed to process Petitioner's request for addition units for holidays. (Exhibit A.6; Testimony).

14. Petitioner would continue to receive the same amount of skill-building assistance and supports coordination as before. (Testimony of Respondent's witness).

15. On 8/9/16, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the denial of Petitioner's request for additional CLS. (Exhibit A.11).

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).

Here, as discussed above, Petitioner has been receiving CLS through Respondent. With respect to such services, 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 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. 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 DHS authorization of amount, scope and duration of Home Help

does not appear to reflect the beneficiary's needs based on the 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 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 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.
>
> 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 DHS 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, October 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 122-123*

However, while CLS are covered services, 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, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 13-14

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will

vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- 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. 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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

MPM, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 119-120

First, regarding the evidence herein, this ALJ notes that it was at times, very confusing. The phone reception of the Respondent's phone was poor. In addition, there were many acronyms used that were not defined; there were references in the Pre-Hearing Summary to the wrong Petitioner; and the statement with the approved authorization states, "…consumer will receive 54.78 hours/week of support services other than CLS." However, on Page 2 of the Pre-Hearing Summary, the facts state that Petitioner received 27.5 skill building hours, and 16.7 AHH services. This does not total 54.78. The actual total is 44.2. It is also unclear if the action here took place; pages from the Hearing Notice is missing regarding fair hearing rights, and time frames.

Be that as it may, despite the fact that this case is highly factually intensive, Petitioner still bears the burden of proof by a preponderance of evidence to show that the Respondent erred in the action it took, or failed to take. The measuring rod is medical necessity, as defined in the MPM.

Here, it is undisputed that Petitioner requires CLS and it is only the amount of hours to be authorized that is at issue, with Petitioner requesting to continue at 47 or more hours per week of CLS, and Respondent only authorizing 21 hours per week of such services. In addition, Petitioner requested an addition number of units/hours over the holidays.

In support of that decision, Respondent's witness testified that Petitioner's CLS are authorized in support of three goals relating to community inclusion, leisure activities, and personal care activities. Respondent's witness also testified that the change in this case was based on a reduction in CLS for community inclusion and leisure activities as Petitioner was also getting assistance with those goals through his skill-building assistance per day. Respondent's witness further testified that CLS is a B3 service and, per policy, such services are not intended to meet all of Petitioner's needs and preferences.

In response, Petitioner's representative testified that Petitioner's caregiver does so much for Petitioner and essentially provides care and supervision 24 hours a day, 7 days a week. The representative also testified that Petitioner's caregiver is both his HHS worker and his CLS worker; she does a wonderful job; and that she is Petitioner's sole support, even though Petitioner leaves every business day from 7:30 a.m. to 2:30 p.m. Petitioner's caregiver further testified that Petitioner sometimes gets up at night and that he attends skill-building services between approximately 7:30 a.m., through 2:30 p.m.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for additional services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed.

While it does not appear that anything has changed with respect to Petitioner's conditions or needs, Petitioner has still failed to show that the denial of additional hours in his most recent plan was improper given the goals of that plan and Petitioner's other services. As discussed above, it is undisputed that Petitioner's CLS was authorized in the amount of 47 hours per week for assistance with community inclusion, leisure activities, and personal care activities. Such a significant amount of services is sufficient to meet those goals given that Petitioner also receives over 16.7 hours of HHS per week; generally sleeps through the night; and attends skill-building services 7 hours per day, where he also interacts with others and the community. Moreover, Petitioner also possesses flexibility to use his services as needed and Petitioner's representative

simply requested more hours in general instead of pointing to any specific goal in the plan that requires more hours.

Additionally, as described in the above policy, B3 supports and services such as CLS "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." MPM, October 1, 2015 version, Mental Health/Substance Abuse Chapter, page 120. Also, in allocating such services, Respondent "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." MPM, October 1, 2015 version, Mental Health/Substance Abuse Chapter, page 120.

Taking into account those policies, the specific goals in his plan and the significant services Petitioner already receives, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof with respect to the action taken regarding his 6 month review and subsequent reduction from 47 to 21 hours per week of CLS hours.

However, Petitioner presented credible and substantial evidence that a request was made for addition unit/hours to cover the 4 holidays during the next 6 months. The PCP Meeting of 5/9/16 clearly states that "In addition to the 47 hours per week being requested an addition 22 hours or (88 units) is being requested for the four days during the next 6 month authorization period in which the day program will be closed which one day for 4th of July, one day for Labor Day and two days for Thanksgiving." (Exhibit A.43). Federal and state law gives a beneficiary a right to have requests reviewed and acted up by the CMH. Here, the CMH failed to do so, and thus, it is reversible error.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides:

Respondent properly reduced Petitioner's CLS hours to 21 per week based on the available evidence. On this issue, the subcontractor here is PARTIALLY AFFIRMED.

Respondent failed to process Petitioner's request for additional holiday CLS hours, and on this issue, the subcontractor CMH is PARTIALLY REVERSED. **IT IS THEREFORE ORDERED** that subcontractor CMH shall immediately process Petitioner's request and issue written notice to Petitioner.

JS/

Janice Spodarek
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

Counsel for Respondent [redacted]

Petitioner [redacted]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]

Authorized Hearing Rep. [redacted]

Agency Representative [redacted]