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: January 4, 2017
MAHS Docket No.: 16-016189
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

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

After due notice, a hearing was held on January 3, 2017. [redacted], Petitioner's mother and guardian, appeared on Petitioner's behalf. [redacted], Petitioner's father, and [redacted], Petitioner's supports coordinator, appeared as witnesses for Petitioner.

[redacted], Assistant Corporation Counsel, [redacted] County Community Mental Health Authority, represented the Department (CMH or Department). [redacted], Access Center Manager, appeared as a witness for the Department.

ISSUE

Did the CMH properly authorize Petitioner's Community Living Supports (CLS) 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 29 year old Medicaid beneficiary, born [redacted], receiving services through [redacted] County Community Mental Health (CMH). (Exhibit A, p 37; Testimony)

2. CMH is under contract with the Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area.

3. Petitioner is diagnosed with severe mental retardation, cerebral palsy, seizures, HRO, and chronic encephalopathy. (Exhibit A, pp 46, 60; Testimony)

4. Petitioner lives in a single family home with her parents and 21 year old brother. Petitioner's father works full-time, Petitioner's mother is Petitioner's primary caregiver, and Petitioner's brother attends school and works full-time. The family does not have any other informal supports. (Exhibit A, pp 37-39; Testimony)

5. Petitioner has an unsteady gait and is nonverbal. She requires total care for all of her needs and she is never left alone. Petitioner has been in special education since preschool and was also homeschooled. (Exhibit A, p 46; Testimony)

6. Petitioner has substantial functional limitations in the area of self-care, receptive and expressive language; learning; self-direction; capacity for independent living and economic self-sufficiency. (Exhibit A, p 59; Testimony)

7. At the time of the request for authorization, Petitioner was receiving the following services: 34.4 hours per week of Community Living Supports (CLS), 15 hours per week of Respite, and 29 hours per week of Adult Home Help (AAH) through the Department of Health and Human Services. However, in the prior authorization period, Petitioner's CLS hours were reduced from 55 hours per week to 34.4 hours per week. (Exhibit A, pp 63, 72; Testimony)

8. On September 23, 2016, following Petitioner's assessment, Petitioner's Supports Coordinator requested that Petitioner's CLS hours be increased to 57 hours per week to make up for the prior reduction. Both Petitioner's mother and Supports Coordinator testified that they were not aware of the prior reduction until Petitioner's mother began to run out of CLS hours at the end of the authorization period. CMH provided a copy of a Notice dated May 1, 2016 which shows the reduction and was mailed to Petitioner's mother on that same date. (Exhibit A, p 6, Exhibit B; Testimony)

9. Following a review of Petitioner's request by the CMH Access Center, Petitioner was approved for 144 units of CLS per week, or approximately 36 CLS hours per week. The Access Center determined that 36 CLS hours per week were sufficient in amount, scope and duration to meet Petitioner's needs and the goals in Petitioner's Individual Plan of Service (IPOS). (Exhibit A, pp 75-89; Testimony)

10. On October 2, 2016, CMH sent Petitioner's mother an Advance Action Notice informing her that the request for 57 CLS hours per week had been denied but that 36 CLS per week had been approved. (Exhibit A, pp 6-8; Testimony)

11. On November 7, 2016, Petitioner'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 (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH 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 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.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- 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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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;
    - 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
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2016, pp 12-14

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.

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, (that exceeds state plan for adults) prompting, reminding, cueing, (revised 7/1/2011), 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2016, pp 120, 122-123
Emphasis added.

CMH's Access Center Manager testified that the Access Center makes level of care determinations for beneficiaries, approves on-going care, and connects beneficiaries with providers. CMH's Access Center Manager reviewed Petitioner's age, diagnoses, living situation, and the current services Petitioner is receiving through CMH. CMH's Access Center Manager indicated that the CLS services Petitioner is receiving are B3 services under the State Plan and are not intended to meet all of Petitioner's needs and preferences. CMH's Access Center Manager reviewed the function of CLS, which includes increasing or maintaining personal self-sufficiency and facilitating an individual's achievement of goals of community inclusion and participation, independence or productivity. CMH's Access Center Manager noted that decisions regarding the authorization of B3 services must take into account the CMH's ability to care for other beneficiaries.

Here, CMH's Access Center Manager indicated that Petitioner's request for 57 CLS hours per week was denied because it was determined that 36 CLS hours per week were sufficient in amount, scope and duration to meet Petitioner's needs. CMH's Access Center Manager testified that the requested CLS hours were not consistent with the needs expressed in Petitioner's most recent Person Centered Plan (PCP). CMH's Access Center Manager noted that Petitioner's PCP allowed 8 CLS hours per week for participating in community outings (Goal 2A); up to 25 hours per week for "constructive activity" (Goal 3A) and up to 25 hours per week for assistance with her ADL's (Goal 3B). However, CMH's Access Center Manager pointed out that Petitioner's February 2016 Adult Services Comprehensive Assessment identifies her as being totally dependent on others for her ADL's and her IADL's and she receives 115.5 hours per month of AHH to assist with these services. CMH's Access Center Manager noted that the remaining 33 hours per week of CLS identified in the PCP for community outings and constructive activity are covered in the 36 CLS hours per week that were authorized.

Petitioner's mother and guardian testified that she was unaware that her daughter's CLS hours were reduced in the prior period until she started running short on CLS hours towards the end of the authorization period. Petitioner's mother and guardian indicated that the family ended up having to pay hundreds of dollars out of pocket to make up the difference. Petitioner's mother and guardian indicated that the request for additional CLS in the current authorization period was simply to get back to the amount of CLS Petitioner had previously been receiving. Petitioner's mother and guardian testified that she is Petitioner's AHH provider and has to assist Petitioner with all of her care. Petitioner's mother and guardian indicated that Petitioner is also incontinent, which requires her bed linens to be changed on an almost daily basis and constant laundry for her clothes. Petitioner's mother and guardian pointed to the Supports Intensity Scale

report completed on Petitioner which shows that she requires almost complete care. (Exhibit 1). Petitioner's mother and guardian testified that Petitioner has been in the hospital five times in the past year and was at the Emergency Department for six hours the night prior to the hearing. Petitioner's mother and guardian testified that the family could barely make it with 55 CLS hours per week and only get by because they are an intact family with excellent, trained staff. Petitioner's mother and guardian testified that she is up most nights with Petitioner because Petitioner barely sleeps and that Petitioner's father cannot get up during the night because he has to work to support the family. Petitioner's mother and guardian indicated that Petitioner's Supports Coordinator does the best that she can, but much of Petitioner's CLS hours are spent taking her to doctor's appointments. Petitioner's mother and guardian testified that the family also has a 21 year old son living at home, but that he is unable to help with Petitioner because he goes to college full-time and works full-time. Petitioner's mother and guardian indicated that Petitioner's father does help, but he also works full-time outside of the home and the family has no other natural supports. Petitioner's mother and guardian pointed out that while the family also receives respite, the respite does not really give the family a break because of Petitioner's high needs.

Petitioner's father testified that he questions how CMH can consider Petitioner's AHH services when determining CLS given that much of the work done for AHH does not include participation by Petitioner.

Petitioner's Supports Coordinator testified that the family struggles to take care of Petitioner every day and that the family has no other natural supports. Petitioner's Supports Coordinator indicated that she also was not aware of Petitioner's reduction in CLS hours during the prior authorization period. Petitioner's Supports Coordinator testified that she is looking at getting Petitioner additional respite hours to properly reflect Petitioner's needs.

Petitioner bears the burden of proving by a preponderance of the evidence that 57 hours of CLS per week are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing 36 hours per week of CLS for Petitioner. Petitioner failed to prove by a preponderance of the evidence that the additional CLS hours were medically necessary.

As indicated above, B3 services are not intended to meet all of a consumer's needs and preferences and the CMH must take into account its ability to serve other beneficiaries. Here, even after the reduction in CLS, Petitioner still receives 36 hours of CLS per week, 15 hours of respite per week, and 29 hours of Adult Home Help per week, for a total of approximately 80 hours of paid support per week. Based on the evidence presented, the current amount of CLS authorized is sufficient in amount, scope and duration to reasonably meet Petitioner's needs. As the CMH correctly pointed out, the requested CLS hours were not consistent with the needs expressed in Petitioner's most recent Person Centered Plan (PCP). Petitioner's PCP allowed 8 CLS hours per week for participating in community outings (Goal 2A); up to 25 hours per week for "constructive activity" (Goal 3A) and up to 25 hours per week for assistance with her

ADL's (Goal 3B). However, Petitioner's February 2016 Adult Services Comprehensive Assessment identifies her as being totally dependent on others for her ADL's and her IADL's and she receives 115.5 hours per month of AHH to assist with these services. As such, the remaining 33 hours per week of CLS identified in the PCP for community outings and constructive activity are covered in the 36 CLS hours per week that were authorized. The parties did discuss the fact that Petitioner might be entitled to more respite hours each week, and Petitioner's Supports Coordinator can make that request during the next authorization.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner's request for 57 CLS hours per week and authorized 36 CLS hours per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

RM/cg

Robert J. Meade
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]

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]