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: February 9, 2017
MAHS Docket No.: 16-016559
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on January 10, 2017. [redacted], Petitioner's legal guardian, appeared and testified on Petitioner's behalf. [redacted], Petitioner's Supports Coordinator, and [redacted], Petitioner's Home Manager, also testified as witnesses for Petitioner. Petitioner was present, but did not otherwise participate. Attorney [redacted] represented the Respondent [redacted]. [redacted], Access Manager, testified as a witness for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a fifty-seven-year-old Medicaid beneficiary who has been diagnosed with mild intellectual disabilities; schizophrenia, paranoid type; and physical impairments. (Exhibit A, page 11; Testimony of Respondent's witness).

2. Through the Michigan Department of Health and Human Services, Petitioner receives approximately 17 hours and 59 minutes of Home Help Services (HHS) per month. (Exhibit A, page 35).

3. Petitioner has also been approved for services through Respondent, including CLS. (Exhibit A, page 39).

4. Prior to the decision at issue in this case, Petitioner was approved for a total of 600 units/150 hours per week of CLS. (Testimony of Respondent's witness).

5. Petitioner's CLS was approved in three separate authorizations, with each authorization having a different ratio of clients to the CLS worker, a 1:1 ratio, a 2:1 ratio or a 3:1 ratio. (Testimony of Respondent's witness).

6. On [redacted], Petitioner's doctor issued a letter stating that Petitioner uses a CPAP machine at night and that monitoring is needed to keep his mask on. (Exhibit A, page 17).

7. The doctor also wrote that Petitioner struggles with healthy eating and needs extra care to monitor him in that area. (Exhibit A, page 17).

8. On October 3, 2016, a Person Centered Planning (PCP) meeting was held with respect to Petitioner's needs and services for the upcoming plan year, November 1, 2016 through October 31, 2017. (Exhibit A, page 33).

9. Goal #2 in the PCP was for Petitioner to continue living where he lives and CLS was to be authorized in support of that goal. (Exhibit A, pages 35-36).

10. Specific objectives identified as part of that goal and amounts identified for assistance with those objectives were training on exercise, 10 hours per week; training on knowing when and how to call 9-1-1, 1 hour per week; training on fire safety, 1 hour per week; working with Petitioner on budgeting, 8 hours a week; assistance with community integration, 26 hours a week; training on laundry, 6 hours per week; training on chores, 12 hours per week; training on cooking, 11 hours per week; training on cleaning, 12 hours per week; assisting Petitioner in getting a haircut, 2 hours a month; training Petitioner to keep his CPAP mask on, 10 hours per week; training on hygiene, 11 hours per week; and training on using the computer to increase spelling, reading and computer functions, 10 hours per week. (Exhibit A, pages 35-36).

11. During the meeting, Petitioner requested the same amount of CLS that he had been approved for the year before. (Testimony of Respondent's representative).

12. On October 27, 2016, Respondent sent Petitioner's guardian written notice that the request for 600 units per week of CLS was denied and that only 377 units per week of such service was approved. (Exhibit A, pages 7-9).

13. The reason given in the notice for Respondent's decision was that the "[s]ervice authorized is sufficient in amount, scope, and duration to reasonably meet PCP goals and expectations of promoting community inclusion and participation, and independence. (Exhibit A, page 7).

14. Specifically, while Petitioner's 1:1 and 2:1 CLS remained the same, his 3:1 CLS was reduced. (Testimony of Respondent's witness).

15. On November 15, 2016, the Michigan Administrative Hearing System received the request for hearing filed on Petitioner's behalf in this matter. (Exhibit A, pages 14-31).

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**
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> 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 (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.

- 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.
>
> *MPM, October 1, 2016 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *Pages 128-129*

However, while CLS is a covered service, 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.

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.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent

	of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age

	of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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. 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 . . .
>
> *MPM, October 1, 2016 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *Pages 125-126*

Here, Respondent denied Petitioner's request for reauthorization of the same amount of CLS authorized in his previous plan year, 600 units/150 hours per week of CLS, and instead only approved a reduced amount of services, 377 units/94.25 hours per week of CLS.

In support of that decision, Respondent's witness testified that she did not make the decision at issue in this case, but has reviewed Petitioner's PCP and the request for CLS, and that she agrees with the reduced authorization that was approved. In particular, she noted that the specific amounts of CLS identified for particular tasks in Petitioner's PCP do not add up to the total amount he was previously approved for and is again requesting. Respondent's witness also testified that her review did not reveal any real training with respect to Petitioner's CPAP machine, with the worker instead just putting the mask back on when it falls off. She further testified that Petitioner's food intake could be monitored in other ways than just having a CLS worker on hand and that Petitioner is high functioning. Respondent's witness further described how Petitioner's CLS is approved in separate blocks of 1:1, 2:1, and 3:1 CLS and that it was just 3:1 CLS that was partially denied, but also noted that Respondent was only looking at the total amount authorized and that Petitioner could change the ratio of workers within his approved hours if necessary.

In response, Petitioner's representative testified that Petitioner's CLS workers do not simply put his CPAP mask back on when it falls off and that they instead prompt Petitioner to do so himself and work with him on recognizing when it has fallen off.

According to Petitioner's representative, Petitioner's sleep apnea is a serious health risk and, while they have looked at CPAP machines that have alarms for when a mask falls off, none are at his level. She also testified that Petitioner's workers are helping him throughout the day with his eating and meal preparation. She further testified that it is not safe for Petitioner to be home alone for more than an hour at a time in case an emergency occurs and that he needs general monitoring for safety concerns.

Petitioner's support coordinator testified that any difference between the amount of specific hours for specific types of assistance identified in the PCP and the amount of CLS that was requested is because of the way Petitioner's CLS was divided up and/or changes in his circumstances.

Petitioner's home manager testified regarding the types of training that the CLS workers do with Petitioner with respect to his CPAP machine, including waking up Petitioner three-to-four times a night after his CPAP mask falls off in order to prompt him to put it back on. She also testified that Petitioner remembers to use the CPAP machine and put on his mask, but that he unintentionally knocks it off during the night.

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

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof in this case and that the 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. Petitioner is authorized for a significant amount of CLS, in addition to his HHS, and the specific hours for CLS identified as part of Petitioner's PCP do not even add up to the amount of CLS he is requesting. Moreover, while Petitioner's representative also testified regarding a general need for monitoring in case of emergencies, such need is not reflected in the letter from Petitioner's doctor or his actual PCP, which also allocates time for training on emergency situations. Similarly, any need for monitoring due to Petitioner's eating habits fails to warrant any additional CLS hours given the supports he is approved for, including assistance with meal preparation; the undisputed fact that he is high-functioning; and the provision in his PCP providing that he can be left alone for up to two hours at a time.

Accordingly, taking into account the above policies, the specific goals in Petitioner's plan and the significant amount of services Petitioner is authorized for, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof with respect to the denial of additional CLS and that Respondent's decision must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for additional CLS.

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED**.

SK/tm

Steven Kibit
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

Agency Representative

[redacted]