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 23, 2017
MAHS Docket No.: 16-017379
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on January 24, 2017. [redacted] represented Respondent [redacted] appeared as a witness for the CMH. [redacted]; [redacted], appeared on behalf of the Petitioner. [redacted], caretaker; [redacted]; and [redacted], appeared as witnesses for Petitioner.

During the hearing proceeding, Petitioner's hearing request was admitted as Exhibit A, pp. 1-4, and the CMH hearing packet was admitted as marked, Exhibits 1-2 pp. 1-9.

ISSUE

Did Respondent properly deny Petitioner's request for Community Living Supports (CLS) at the equivalent of 152.75 hours per week for six months and instead authorized CLS at the equivalent of 152.75 hours per week for 60 days?

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 [redacted] Medicaid beneficiary, date of birth [redacted] (Exhibit 2, p. 7)

2. On October 6, 2016, the CMH received a request for the equivalent of 152.75 hours per week for six months. (Exhibit 1, p. 3; Access Manager Testimony)

3. In reviewing this request, the CMH determined that Petitioner's CLS hours would remain unchanged at the equivalent of 152.75 hours per week, but the authorization would be limited to 60 days to continue providing the current level of service to facilitate discussion of whether Petitioner was in the most appropriate environment to meet her needs or possibly if a group home would be more appropriate. (Access Manager Testimony)

4. On October 12, 2016, a letter was issued to Petitioner's Guardian indicating the request for the equivalent of 152.75 hours per week of CLS for six months was denied and instead CLS was authorized at the equivalent of 152.75 hours per week for 60 days. (Exhibit 1, pp. 3-5)

5. On November 28, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Petitioner's behalf in this matter. (Exhibit A, pp. 1-4)

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).

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.). Medicaid Provider Manual (MPM), *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2016 version, p. 128.*

While CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. The MPM sets forth the medical necessity criteria:

> **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:
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  - 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, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2016, version, pp. 13-14

Additionally, the MPM sets forth the criteria for authorizing B3 Supports and Services, such as CLS:

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

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and

> preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.
>
> 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, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2016, version, p. 126*

In this case, the amount of Petitioner's CLS hours did not change, rather the CMH approved a shortened 60 day period instead of the requested six month period.

On October 6, 2016, the CMH received a request for the equivalent of 152.75 hours per week for six months. (Exhibit 1, p. 3; Access Manager Testimony)

In reviewing this request, the CMH determined that Petitioner's CLS hours would remain unchanged at the equivalent of 152.75 hours per week, but the authorization would be limited to 60 days to continue providing the current level of service to facilitate discussion of whether Petitioner was in the most appropriate environment to meet her needs or possibly if a group home would be more appropriate. It was noted that CLS is really not intended to meet all of a person's needs on an ongoing basis. Rather, they are intended for skill development to move toward greater independence. Petitioner's medical issues, how long she had been receiving services at this level, and progress made were all considered. In part, the clinical record was reviewed and the Access Center psychiatrist was consulted. It did not appear that Petitioner was acquiring skills to be more independent in the community. It looked as though Petitioner's medical and safety needs would be more appropriately met in another setting, such as a specialized

residential group home. This is considered a higher level of care than independent living with CLS services. The recommendation for a specialized group home appeared to be the most medically appropriate level of care for Petitioner. (Access Manager Testimony)

On [redacted], a letter was issued to Petitioner's Guardian indicating the request for the equivalent of 152.75 hours per week of CLS for six months was denied and instead CLS was authorized at the equivalent of 152.75 hours per week for 60 days. (Exhibit 1, pp. 3-5)

Petitioner's Guardian and representatives asserted that to move Petitioner would be a grave injustice given her cognitive disorder and disability with anxiety. It was explained that Petitioner was moved into her apartment after the state took her home when her mother passed away and she has lived there for [redacted] years. It was asserted that Petitioner may not last if she is moved to an adult foster care (AFC) home at this point. Further, it was noted that the contested authorization was only for 60 days, which has not been sufficient time. Things have not occurred in the expected time frames, such as the attempts to set up a pre-placement visit. (Guardian, Advocate, and Case Manager Testimony)

The CMH confirmed that they have and will continue to extend this CLS authorization while there are continuing efforts to look into and work on placement. (Access Manager Testimony)

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for CLS at the equivalent of 152.75 hours per week for six months and instead authorizing CLS at the equivalent of 152.75 hours per week for 60 days. Given the evidence and applicable policies in this case, Petitioner has not met her burden of proof and Respondent's decision must be upheld. Petitioner's CLS hours were not changed, only the length of the authorization was shortened. The CMH explained that at this time, it appears that Petitioner's medical and safety needs may be more appropriately met in under a different level of care. Accordingly, the CMH approved the current amount of CLS for the shortened period to facilitate looking into alternative placement. Further review would be needed at the end of the shortened authorization period to determine the appropriate services authorization at that time. Indeed, the CMH credibly testified that they extended the authorization for an additional 30 days at the current level and will continue to do so as long as there are continuing efforts to look into and work on placement. The [redacted], determination to reduce the length of the services authorization for Petitioner was in accordance with the MPM policies to approve medically necessary supports and services and the criteria for authorizing B3 supports and services.

As discussed there is no jurisdiction to review concerns or issue any orders regarding the appropriateness of future service determinations for Petitioner. If there is disagreement with any future services determinations, a timely hearing request can be filed at that time.

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 CLS at the equivalent of 152.75 hours per week for six months and instead authorized CLS at the equivalent of 152.75 hours per week for 60 days.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

CL/cg

Colleen Lack
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]

[redacted]

[redacted]

DHHS-Location Contact

[redacted]

[redacted]