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: March 10, 2017
MAHS Docket No.: 16-015531
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

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 commenced on January 10, 2017, and was completed on February 3, 2017. [redacted] Attorney, [redacted]., represented the Petitioner. [redacted], mother and Guardian; [redacted], Psychologist; and [redacted], Associate Superintendent of Special Education Services, appeared as witnesses for Petitioner. [redacted], Attorney, General Counsel, represented [redacted] Community Mental Health (CMH). [redacted], Clinical Supervisor; [redacted], Clinical Behavioral Psychologist Supervisor, and [redacted], Treatment Specialist; appeared as witnesses for the CMH.

During the hearing proceeding, the CMH's January 4, 2017, hearing summary packet was admitted as Exhibit 1, pp. 1-106; the CMH's January 19, 2017, hearing summary packet was admitted as Exhibit 2, pp. 1-19; and Petitioner's Exhibit packet was admitted as marked, Exhibits A-F.

ISSUE

Did the CMH properly propose a reduction of the Community Living Supports (CLS) hours for a second staff person during daytime 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 twenty six (26)-year-old Medicaid beneficiary who has been diagnosed with autism spectrum disorder, other problems related to psychosocial circumstance, unspecified constipation, and unspecified problem related to social environment. (Exhibit 1, p. 14)

2. It was stipulated that Petitioner has been receiving services through the Habilitation Supports Wavier for Persons with Developmental Disabilities (HAB Waiver).

3. Petitioner lives in his own home with 24 hour staffing, including a second staff member from 9:00 am to 10:00 pm daily. (Exhibit 1, p. 7)

4. On March 29, 2016, a Behavior Assessment was completed. (Exhibit 2, pp. 3-9)

5. The CMH determined that the current CLS staffing level was no longer medically necessary.

6. On October 18, 2016, an Individual Plan of Service (IPOS) Meeting was held. In part, it was proposed that Petitioner's second staff be reduced to 8 hours per day to allow him to engage in his desired activities within the community. (Exhibit 1, p. 21)

7. On October 25, 2016, the Behavior Support Plan was revised. (Exhibit 1, pp. 61-69)

8. On October 27, 2016, the IPOS was amended to allow for an extension of the current plan because Petitioner's Guardian did not agree with the new plan and it was anticipated that an administrative hearing request would be filed. (Exhibit 1, pp. 70-102)

9. On October 27, 2016, an Adequate Action Notice was issued to Petitioner's Guardian regarding the new IPOS. (Exhibit 1, pp. 59-60)

10. At the time of an October 28, 2016, Bio-Psycho-Social Assessment, it was noted that Petitioner demonstrated stable behavior over a 6-8 month period and had participated in activities successfully at home and in the community. Accordingly, it was indicated that having two staff was no longer needed to keep Petitioner successful. (Exhibit 1, pp. 5 and 7)

11. On November 1, 2016, an Adequate Action Notice was issued to Petitioner's Guardian regarding the continuation of the May 31, 2016, IPOS. (Exhibit 1, pp. 105-106)

12. On November 1, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Petitioner's behalf in this matter. (Hearing Request)

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 396n(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).

With respect to CLS through the Habilitation Supports Waiver, the Medicaid Provider Manual (MPM) provides:

> **COMMUNITY LIVING SUPPORTS (CLS)**
>
> Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:
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> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
>
> - Meal preparation;
>
> - Laundry;
>
> - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
> - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
> - Shopping for food and other necessities of daily living.
>
> - Assistance, support and/or training the beneficiary with:
> - Money management;
> - Non-medical care (not requiring nurse or physician intervention);
> - Socialization and relationship building;
> - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS

or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
- Leisure choice and participation in regular community activities;
- Attendance at medical appointments; and
- Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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 must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. 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.

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 Chapter, pages 103-104

With respect to CLS through as a B3 Support and Service, 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 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 Chapter, pages 128-129*

While CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. The Medicaid Provider Manual (MPM) sets forth the criteria for medical necessity Medicaid mental health, developmental disabilities, and substance abuse supports and services:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
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> **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, 2016 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 13-14*

In this case, Petitioner lives in his own home with 24 hour staffing, including a second staff member from 9:00 am to 10:00 pm daily. (Exhibit 1, p. 7) The CMH determined that the current CLS staffing level was no longer medically necessary and proposed reducing the second staff to 8 hours per day, which would still allow Petitioner to engage in his desired activities within the community. (Exhibit 1, p. 21). The Clinical Supervisor explained that this was based upon the data over the past 1-2 years and consultation with the Clinical Behavioral Psychologist Supervisor. It was noted that there had been prior plans to decrease the second staff by one hour per quarter, but due to the Guardian's refusal there had been no further reductions for two years going into a third year. The CMH has confirmed with the staffing agency that with the reduction, they will still be able to ensure that there will still be two staff for any planned activities in the community. It was noted that Petitioner benefits from a planned schedule and rarely would leave home on whim. Further, the second staff person from an outing would be able to stay if there were a situation when Petitioner returned home as part of the precautions in place with the safety plan. (Clinical Supervisor Testimony)

The Clinical Behavioral Psychologist Supervisor testified that he sees Petitioner quarterly and has reviewed the data collected from the staff working with Petitioner in his home. There has been a marked decrease in Petitioner's behaviors over the last 12 months. The Clinical Behavioral Psychologist Supervisor does not believe there would be a high risk that the reduction of the second staff by 5 hours would lead to an increase in self injurious behavior or aggression if implemented with strategies that have been successful with Petitioner, such as the use of social stories about a week prior. (Clinical Behavioral Psychologist Supervisor Testimony)

The Treatment Specialist testified that she works full time on the 11:00 pm to 7:00 am shift in Petitioner's home. When Petitioner has engaged in self-injurious behavior during her shift, the Treatment Specialist has been able to manage this on her own. Petitioner has been doing good over the past 12 months and the Treatment Specialist noted she has not had to call Petitioner's Guardian for quite some time. Some nights Petitioner is up and restless, but he has been re-directable. Further, the Treatment Specialist would have to check the documentation, but thought that it had been at least one year since she observed Petitioner being aggressive. The Treatment Specialist also described recent success with adapting to change, such as when Petitioner's father had to cancel with short notice. (Treatment Specialist Testimony)

Petitioner asserts that the proposed reduction by 5 hours per day is too abrupt and that this reduction was not done in accordance with the September 9, 2016, Decision and Order from a prior administrative hearing, MAHS Docket No.: 16-006639. However, the contested action from the September 9, 2016, Decision and Order was a proposed discontinuation of the second staff person altogether. The analysis in that decision did note that witness from both parties indicated that a stepped down approach to eliminating the second staff person would be most likely to be successful for Petitioner; and that it was suggested by the witness that such an approach would involve a team including the CMH professionals, direct care staff, and Petitioner's mother/guardian. Further, it was suggested that the process would be data based with the professionals driving the decisions to make reductions to Petitioner's CLS based on review of the data as steps toward eliminating the second staff person are implemented. MAHS Docket No.: 16-006639, p. 12 of 14. However, the actual order only stated that the CMH must initiate developing a new IPOS outlining the appropriate amount, scope and duration of CLS services. MAHS Docket No.: 16-006639, p. 12 of 14.

Regarding the 5 hour reduction being too abrupt, Petitioner provided extensive tesimony from a Psychologist who was previously involved in Petitioner's case with the CMH. While the Psychologist also believed that the CLS hours for the second staff person could be reduced and possibly eventually eliminated, he indicated the likelihood of success would be increased if done in a certain way. It was suggested that this be done by implementing smaller decreases, such as 1 hour at a time. However, it was noted that the Psychologist last consulted on Petitioner's case in 2015. (Psychologist Testimony) Accordingly, the Psychologist's concerns and suggestions for how to implement the reductions for the second staff person are given more limited weight than the professionals currently involved with Petitioner's CMH case.

The Associate Superintendent of Special Education Services testified that she has been familiar with Petitioner from the school based situation since the 6th grade. The Associate Superintendent of Special Education Services has seen Petitioner agitated, for example when he does not understand what will be going on next. It was noted that Petitioner does best with a rigid routine. Petitioner has a history of behaviors including hand to chins and a change in schedule can lead to such self-injurious behaviors. The Associate Superintendent of Special Education Services had not seen Petitioner strike others in the past year and a half. (Associate Superintendent of Special Education Services Testimony)

Petitioner's mother acknowledged that Petitioner likes to know what will be happening, but asserts that he is also interested in new things and will do some spontaneous activities. For example, Petitioner may want to go to [redacted] to get socks, go for a walk or to the museum. Petitioner's mother encourages Petitioner to do things, especially in the summer when there are special activities like the 4th of July fireworks and a 3 day music festival. Petitioner also goes on overnight trips, which have deceased from four times per year to twice per year. It was asserted that Petitioner needs two staff for these activities. Petitioner does have anxiety during the day and one staff person cannot always handle that. Petitioner's mother is concerned as Petitioner has never

had a big change like the proposed 5 hour reduction. Petitioner's mother noted that in the past she has consented to the smaller reductions of one hour at a time, for which she was involved with the treatment team, and the hours have been reduced from 16 hours to 13 hours for the second staff person. It was asserted that Petitioner's mother was not involved with this proposed reduction, rather she was just told the 5 hour cut would occur. Lastly, Petitioner's mother does not believe there is 5 hours that can be cut per day without interfering with Petitioner's activities. (Mother Testimony)

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in proposing the 5 hour reduction in CLS hours for the second staff person. Given the evidence and applicable policies in this case, Petitioner has not met his burden of proof and Respondent's decision must be upheld. The proposed reduction does not require Petitioner to choose a 5 hour block of time on a given day to eliminate the second staff person. Rather, the Clinical Supervisor credibly testified that the CMH confirmed with the staffing agency that that with the reduction, they will still be able to ensure that there will still be two staff for any planned activities in the community. As several witnesses acknowledged, Petitioner does best with a planned schedule. The evidence does not establish medical necessity for continuing the second staff person at 13 hours per day. Further, the proposed reduction still allows for 8 hours of CLS per day for a second staff person when Petitioner is out in the community. The CMH's evidence supports that this is sufficient to meet Petitioner's medically necessary needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly proposed a reduction of the Community Living Supports (CLS) hours for a second staff person during daytime hours.

IT IS THEREFORE ORDERED that

The CMH's decision is AFFIRMED.

Colleen Lack

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

Petitioner [redacted]

DHHS -Dept Contact [redacted]

Counsel for Petitioner [redacted]

DHHS Department Rep. [redacted]