



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 27, 2017
MAHS Docket No.: 17-001006
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 March 15, 2017. Petitioner's Father and Legal Guardian [REDACTED]; his mother [REDACTED] and Supports coordinator, [REDACTED] appeared on behalf of the Petitioner. [REDACTED], Assistant Corporation counsel (P [REDACTED]) and [REDACTED], Access Center Manager represented the [REDACTED] County Community Mental Health [REDACTED] or Respondent).

Respondent's Exhibit 1-6 (pages 1-68) were admitted as evidence.

ISSUE

Did the [REDACTED] determine the proper amount of Community Living Supports that should be granted to Petitioner?

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 Medicaid beneficiary, date of birth [REDACTED].
2. On January 20, 2017, Petitioner's father and Guardian requested 50 hours per week of community living supports (Exhibit 1, page 8)
3. On January 25, 2017, [REDACTED] County Community Mental Health Access Center denied the request for 50 hours per week but did authorize 25 hours per week of community living supports, stating "that service authorized is sufficient in amount, scope and duration to reasonably meet age appropriate goals and expectations of promoting community inclusion and participation and independence. Plan

indicates an interest in skill building. Exploring this option would benefit the consumer with community inclusion. Reviewed case in community living supports meeting the psychiatrist and access supervisor.” (Exhibit 2, page 10).

4. On January 31, 2017, Petitioner’s father filed a timely request for hearing.
5. On February 1, 2017 the Michigan Administrative Hearing System received a request for hearing from Petitioner’s father stating that Petitioner needs to be watched 24/7 because he would escape house and he also has no fear of danger. Petitioner is currently ■ years old and has Arthrogryposis of the lower extremities making it hard for him to walk. He is cognitively impaired, nonverbal and has sleep apnea. The community living service service hours were reduced from 50 to 25 hours per week and the behaviorist was reduced from one visit per month to know visits.
6. The record indicates that Petitioner does receive a behaviorist and that portion of the request for hearing was withdrawn at the hearing.
7. Petitioner needs full physical assistance was showering, brushing his teeth, brushing his hair and dressing. He is not toilet trained. Petitioner does not understand when he has to use the bathroom. He requires two people to transfer him from his wheelchair to the inside of a car and couch. He has a lift system in his house which assist his mother and CLS staff with transferring him from his wheelchair into the shower and on the bed. Petitioner’s nonverbal but is able to say a few simple words such as *mom, dad, ball, me* and *you*. He cannot verbalize his wants and needs. (Exhibit 4, pages 24-25)
8. Petitioner’s goals and objectives for community living supports are as follows: Access with the community (15 hours per week); shopping in the community (2 hours per week); CLS staff will assist during shopping outings (two hours per week); practice money management skills (two hours per week); CLS staff monitoring use of U – scan service at stores (two hours per week); household chores (seven hours per week); CLS assistance with daily physical strengthening exercise (14 hours per week); monetary transactions in the community (2.5 hours per week); use of communication device (seven hours per week); Access community recreation center (six hours per week). (Exhibit 5, pages 51 – 52)
9. Petitioner receives 110 hours per month (25.6 hours per week) of adult home help care services. (Exhibit 5 page 51)
10. There is no goal for allocation of hours in the person center plan for skill building.

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).

The Michigan Mental Health Code explicitly states:

330.1712 Individualized written plan of services.

Sec. 712.

(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

The Michigan Mental Health Code, Section 330.1100a, defines developmentally disabled as:

(21) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

(i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.

(ii) Is manifested before the individual is 22 years old.

(iii) Is likely to continue indefinitely.

(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

The Individual Plan of Services shall address the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation. (Michigan Mental Health Code 330.1712).

Medicaid beneficiaries are only 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. Medical necessity is defined by the Medicaid Provider Manual as follows:

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,
January 1, 2017, pp 13-14*

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPORTS AND SERVICES states:

The goals 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 meets 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 ensure 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 are typical in his community; and without such services and supports, would be impossible to obtain.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES states:

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.

***Behavioral Health and Intellectual and
Developmental Disability Supports and Services,
Date: April 1, 2016, page 120***

The *Medicaid Provider Manual, Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan. It states with regard to community living supports:

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, reminding, 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 health 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.

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.

***MPM, Behavioral Health and Intellectual and
Developmental Disability Supports and Services,
Date: April 1, 2016, page 128-129***

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

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.**

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, Behavioral Health and Intellectual and
Developmental Disability Supports and Services,
Date: April 1, 2016, page 123***

Petitioner's mother asserts that Petitioner continued to expand a lot of anxiety and is not able to sleep alone at night. His mother sleeps with them during the night so they can feel safe. Petitioner's mother reports that she does not stay in the room with Petitioner or the people screaming get out of bed. She is not able to spend time with her husband alone do to Petitioner's anxiety. The family does get some relief from CLS and respite staff, the mother reports that she rarely leaves the house without him.

The intention of Community Living Supports is skills acquisition for increased independence. Petitioner needs full assistance with all Activities of Daily Living, household and community access tasks.

Community Mental Health has determined that Petitioner has established Medical Necessity for the CLS services and granted Petitioner CLS services when he might more appropriately be served through a Medicaid Waiver Program or other programs, which may offer a host of enhanced services. Since MCCMH has established that CLS are medically necessary services for Petitioner, it must establish why the services should be reduced, when Petitioner's condition has not materially changed or has worsened.

The notice indicates that the reason for the action is that service authorized is sufficient in amount, scope and duration to reasonably meet age appropriate goals and expectations of promoting community inclusion and participation and independence. Petitioner does not agree when he has been receiving double the amount of CLS in the past. Unfortunately, the notice does not specifically justify why the CLS services should be reduced to 25 hours when the person centered plan reflects at least 61 hours per week.

Respondent argues at the hearing that the goals in the person center plan are duplicative or overlapping. Petitioner receives 26.5 hours per week in home help services which covers household chores. Exploring the option of skill building would benefit the consumer with community inclusion. The evidence on the record clearly indicates Petitioner will never acquire skills which will allow him to live independently or

even with increased independence based upon the fact that he has had his condition since birth.

This Administrative Law Judge finds that the evidence on the record indicates that CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Petitioner should receive 25 hours per week in Community Living Service hours based upon his current circumstances. Based on Petitioner's current Individual Plan of Service (IPOS), 25 hours of CLS per week, in conjunction with other approved services is sufficient in amount, scope and duration to meet Petitioner's medically necessary needs.

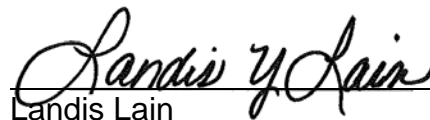
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized CLS in an amount that is sufficient in scope and duration to reasonably allow Appellant to achieve his IPOS goals under the circumstances.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

LL/sb



Landis Lain

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]

Petitioner

[REDACTED]

DHHS -Dept Contact

[REDACTED]

DHHS-Location Contact

[REDACTED]

Authorized Hearing Rep.

[REDACTED]