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 21, 2017
MAHS Docket No.: 16-016388
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 February 2, 2017 and continued on February 8, 2017. [redacted] appeared on behalf of the Petitioner. [redacted] and [redacted] offered testimony on behalf of the Petitioner. Barbara Laughbaum, appeared and offered testimony on behalf of Pathways (Department).

Exhibits:

Petitioner
1. Miscellaneous Records[1]
2. Miscellaneous Records[2]
3. Miscellaneous Records[3]

Department
A. Hearing Packet

[1] Includes: Timeline of Concerns (5 pages), Letter from Dr. Hardie (1 page), Introduction and Overview Letter (8 pages), Support I Provide for Alec letter (2 pages).
[2] Includes: November 11, 2016 Advance Negative Action letter (1 page), CLS Documentation (7 pages).
[3] These were offered but not admitted due to questions regarding relevancy, authentication, hearsay and to avoid duplicative submissions: December 14, 2016 Psychological Evaluation (6 pages), January 19, 2017 letter (1 page), January 20, 2015 letter from Marquette General Hospital (2 pages), January 24, 2017 letter from Dr. Cynthia Wiggins (1 page), January 3, 2017 letter from Emily Bardwell (1 page), Undated letter from Tattra Han (spelling) (1 page), Representation Authorization and Medical Release (3 pages), January 18, 2017 Durable Power of Attorney (9 pages), 1st Key concerns Draft (2 pages), January 28, 2017 letter from Laurie Smith, PT (1 page), February 5, 2016 letter to Sara Rymkos (2 pages), July 11, 2016 IPOS notes (3 pages), July 25, 2016 letter to Sarah Rymkos (4 pages), Same Questions from FISH assessment (2 pages), Random IPOS progress notes from Previous plans (4 pages), Post Negative Action letters regarding policies and procedures (9 pages), Northcare Network policy (1 page), October 22, 2015 Thomas Renwick letter (1 page), Excerpt from Medicaid Contract (2 pages).

ISSUE

Did the Department properly reduce the Petitioner's Community Living Supports (CLS) hours?

FINDINGS OF FACT

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

1. The Department is under contract with the Michigan Department of Health and Human Services to provide Medicaid covered services.

2. Petitioner is a [redacted] year-old female who has been diagnosed with Asperger's disorder, anxiety, hypothyroidism, occipital neuralgia, temporal epilepsy, right occipital neuralgia and seizure disorder and who has been receiving services through the CMH. (Exhibit A, p. 13; Testimony.)

3. Petitioner has a history of multiple nonverbal behaviors to regulating her social interaction that includes self-harm. (Exhibit A, p. 13; Testimony.)

4. In February of 2016, Petitioner's plan was triggered in a Department system for a medical necessity review. (Testimony.)

5. Between February of 2016 and August of 2016, Petitioner's file was reviewed for medical necessity. (Testimony.)

6. In July 2016, the Department recommended the Petitioner participate in an occupational therapist (OT) evaluation to assess the Petitioner's ability to complete Activities of Daily Living (ADL's). (Exhibit 1; Testimony.)

7. On September 28, 2016, the Petitioner participated in an OT evaluation. The evaluation consisted of an interview with the Petitioner and the Petitioner's mother and observation of the Petitioner in the Petitioner's home. (Exhibit A, p. 21.)

8. During the OT evaluation, Petitioner was observed performing and completing independently the ADL tasks of dressing, toileting, grooming and showering. (Exhibit A, p. 21.)

9. At the time of the OT evaluation, the Petitioner was able to drive and had her own car; was able to prepare simple meals/snacks independently and warm up food; able to feed herself; and able to clean her home with reminders. At the time of the OT evaluation, it was indicated the Petitioner received assistance with medication preparation; assistance with time management; and assistance with money management. (Exhibit A, p. 22;

Testimony.)

10. Based upon the OT evaluation, the evaluator concluded the Petitioner had some difficulty with the planning, prioritizing, organizing and management of her ADL's and Instrumental Activities of Daily Living (IADL's) and as a result recommended 7 to 8 hours a week of CLS programing to help the Petitioner increase her independence. The evaluator recommended 203 hours per week for finding recipes, making a list and grocery shopping, 2 hours per week for cooking skills and modifying recipes, 1 hour per week to observe/discuss hygiene, 1 hour a week for time management skills and 1 hour a week for cleaning skills/plan and money management planning. (Exhibit A, pp. 22, 24; Testimony.)

11. Prior to November 11, 2016, the Petitioner was approved for and receiving 35 CLS hours a week. (Exhibit 1; Testimony.)

12. In preparation for a November 2016 Individual Plan of Service (IPOS) meeting, the Department reviewed the results of the September 28, 2016 OT evaluation; Department CLS monthly progress forms and Bio-Psycho-Social Assessment. At this time, the Department determined the Petitioner's CLS hours should be reduced to 16 hours a week. (Testimony.)

13. On or around November 10, 2016, the Department communicated to the Petitioner that there would be a CLS reduction down to 16 hours. (Testimony.)

14. On November 10, 2016, an IPOS meeting was to take place. The Petitioner and the Petitioner's mother elected not to participate in the IPOS meeting and indicated they would not be signing the proposed IPOS. (Exhibit A, p. 26.)

15. On November 11, 2016, the Department sent the Petitioner an Adequate Action notice. The notice indicated the Petitioner's CLS hours would be reduced effective November 15, 2016.[4]

16. On November 14, 2016, the Michigan Administrative Hearings System (MAHS), received from the Petitioner a request for hearing.

17. Petitioner's providers document in the Department CLS progress notes every time the Petitioner self-harms. (Testimony.)

[4] Petitioner argued that the reduction highlighted in the negative action notice should have been provided at least 10 days in advance of the effective date. The Petitioner is correct in that regard. However, the Petitioner continued to receive the former allocation of services pending the hearing and as a result, the Petitioner was not directly harmed by the faulty notice provided. Consequently, this issue will not be addressed any further.

18. The CLS progress notes from October 2015 through July 2016 do not reflect any situations of self-harm. (Exhibit 2.)

19. On October 17, 2016, the administrator of the OT evaluation

20. Petitioner is able to communicate his needs and wants; and can complete basic daily personal care and Activities of Daily Living with supervision and prompts. (Exhibit A, p. 28; Testimony).

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

Additionally, 42 CFR 430.10 states:

> 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 also 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 Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided pursuant to that waiver are CLS and, with respect to those services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **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 the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. 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 DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the 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 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 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 DHS 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, January 1, 2017*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter,*
> *pp 128-129.*

However, while CLS are covered services, 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 applicable version of the MPM states:

> **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.
>
> *MPM, January 1, 2017*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pp 13-14.*

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.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

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

service definitions, as applicable.

> Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.
>
> Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.
>
> *MPM, January 1, 2017*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter,*
> *pp 125-126.*

Pursuant to the above policies, the Department determined that 16 hours per week of CLS services was medically necessary and that the request for additional hours could not be medically justified. Petitioner challenges that decision and as such bears the burden of proving by a preponderance of the evidence that the Department's decision was inappropriate.

Here, Petitioner has failed to meet that burden of proof and the Department's decision must therefore be affirmed. As noted by the Department, the services provided are based on the goals and needs identified in the IPOS and in accordance with medical

necessity guidelines. The IPOS provided on appeal and for Department review did not identify a need in excess of what was allocated. The IPOS identified an estimated need of 16 hours a week[5].

The Petitioner argued the Department erred by relying on a Functional Independence Skills Handbook (FISH) assessment and the fact the time approved was insufficient and would have a major negative impact on the Petitioner's progress.

The Department however did not solely rely on a FISH assessment in determining medical necessity. Rather the OT evaluator used FISH as a guide in a non-standardized manner. Additionally, the Petitioner did not provide any objective evidence to demonstrate the current allocation of 16 hours was insufficient. In arguing that 16 hours was insufficient, the Petitioner primarily relied on testimony from two providers and the Petitioner's primary care physician (PCP). Both providers and the PCP indicated the Petitioner needed lots of verbal prompting and redirecting. However, they did not indicate how the current allocation of 16 hours a week would be insufficient to accomplish the goals laid out in the IPOS.

Based upon the evidence presented, the Petitioner has failed to demonstrate that the Department erred in denying the Petitioner's request for 104 CLS hours a week and the Department's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced the Petitioner's CLS allocation.

IT IS THEREFORE ORDERED that:

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

CA/sb

Corey Arendt
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

[5] 8 hours more than what was recommended by the OT assessment (see Exhibit A, p 21).

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]
[redacted]
[redacted], MI
[redacted]

Authorized Hearing Rep.

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DHHS -Dept Contact

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