[redacted]
[redacted], MI [redacted]

Date Mailed: April 27, 2020
MOAHR Docket No.: 20-000926
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 Appellant's request for a hearing.

After due notice, a hearing was held on April 21, 2020. [redacted], Petitioner's Brother and Legal Guardian, appeared on behalf of the Petitioner. Anthony Holston, Assistant Vice President of Appeals and Grievances, appeared on behalf of Respondent (Department). Kari Kempema, Adult Mental Health Services Manager for Network 180, appeared as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny Petitioner's Community Living Supports in a Licensed Residential Setting?

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, born [redacted], receiving Medicaid benefits from the Department. (Exhibit A, p 14; Testimony).

2. Petitioner is diagnosed with schizoaffective disorder, confusion, depression and anxiety. (Exhibit A, p 19).

3. As of March 2019, Petitioner resided at ACARE Homes, a licensed AFC home and was approved for a CLS daily rate of $[redacted]. ACARE Homes is licensed as an Adult Small Group Home serving aged, developmentally

disabled and mentally ill and has special certifications for the developmentally disabled and mentally ill.[1] (Exhibit A, pp 47-48; Testimony).

4. In or around March 2019, Petitioner requested a continuation of the CLS daily rate of $[redacted]. (Testimony).

5. As of March 2019, Petitioners Individualized Plan of Service indicated Petitioner required cues/reminders for meal planning, changing himself and exercise (walks). (Testimony).

6. On June 20, 2019, Department sent Petitioner notification indicating the request was denied and that the CLS daily rate would be terminated effective July 2, 2019. (Exhibit A, p 11; Testimony).

7. On September 19, 2019, Petitioner requested a local level appeal. (Exhibit A, p 2).

8. On October 18, 2019, the Department sent Petitioner a notice of denial. The Notice indicated the initial denial was affirmed. (Exhibit A, pp 2-3).

9. On February 13, 2020, the Michigan Administrative Hearings System received from Petitioner, a request for hearing.

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.[2]

[1] Judicial Notice of the Homes licensure. Neither party disputed the licensure. Information was taken directly from adultfostercare.apps.lara.state.mi.us/Home/FacilityProfile/326.
[2] 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.[3]

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…

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 (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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.[4] In order to assess what services are medically necessary, and therefore Medicaid-covered, the Department performs periodic assessments.

The Medicaid Provider Manual (MPM) articulates Medicaid policy for Michigan. Regarding medical necessity, it states, in relevant part:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

[3] 42 CFR 430.10.
[4] 42 CFR 440.230.

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 enough 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:

- 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.[5]

Furthermore, there are limitations on the scope, duration and amount of CLS services that can be provided when an individual resides in an AFC home.

Adult Foster Care

Adult foster care family homes, small group homes, large group homes and congregate facilities are licensed by the Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) under Act 218 Public Acts of 1979. These facilities provide:

- Room and Board.
- Supervision 24/7.
- Protection.
- Personal care to adults 18 and over who are frail, developmentally disabled, mentally ill, or intellectually or physically disabled.

The individuals that would need supervision on an ongoing basis but not

[5] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, January 1, 2019, pp 13-14.

the services of continuous nursing care are the best candidates for Adult Community Placement facilities.[6]

* * *

Foster Care Defined – MCL 400.704(6)

Foster care means provision to non-related adults of supervision, personal care and protection in addition to room and board for 24 hours a day, 5 or more days a week, and for 2 or more consecutive weeks for compensation.

Supervision Defined – MCL 400.707(7)

Supervision means guidance of a resident in the activities of daily living including all of the following:

(a) Reminding a resident to maintain his or her medication schedule as directed by the resident's physician.

(b) Reminding a resident of important activities to be carried out.

(c) Assisting a resident in keeping appointments.

(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.

Personal Care Defined – MCL 400.706(1)

Personal care means **personal assistance** provided by a licensee or an agent or employee of the licensee to a resident who requires assistance with:

- Dressing.
- Personal hygiene.
- Grooming.
- Maintenance of a medication schedule as directed and supervised by the adult's physician
- The development of those personal and social skills required to live in the least restrictive environment.[7]

[6] Act 218 of 1979.
[7] Adult Services Manual 050, October 1, 2016, pp 1, 5-6.

Additionally, the Department of Consumer and Industry Services has established rules for licensed adult foster care small group homes.

R 400.14301 addresses resident admission criteria; assessments etc.

Rule 301 (2): A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:

(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
(c) The resident appears to be compatible with other residents and members of the household.

R 400.14303 addresses resident care.

Rule 303 (1): Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident’s physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.

Rule 303 (2): A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident’s written assessment plan.

Rule 303 (3): A licensee shall assure the availability of transportation services as provided for in the resident care agreement

Rule 303 (4): A licensee shall provide all of the following:
(a) An opportunity for the resident to develop positive social skills.
(b) An opportunity for the resident to have contact with relatives and friends.
(c) An opportunity for community-based recreational

activities.
(d) An opportunity for privacy and leisure time.
(e) An opportunity for religious education and attendance at religious services of the resident's choice.

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS [CHANGE MADE 10/1/18]

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care or child caring institution (CCI) **(text added 10/1/18)** setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;

- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

“Assisting” means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS [CHANGE MADE 10/1/18]

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care or a CCI setting licensed and certified by the state under the 1987 Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended. **(revised 10/1/18)**

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.[8]

The Department argued that the documentation provided and reviewed did not reflect a medical need for CLS services. Specifically, the witness indicated that the documentation provided, identified several goals that did not require anything more than verbal prompts/reminding.

Petitioner in this matter, bears the burden of proving by a preponderance of the evidence that authorization of personal care and community living supports is medically necessary. The Department provided sufficient evidence that it adhered to federal regulations and state policy when denying community living supports. And the Petitioner failed to prove by a preponderance of the evidence that the additional services were medically necessary.

Petitioner indicated that there have been no changes since last year except for a deterioration in Petitioners health. Petitioner also indicated they were unaware that the Individualized Plan of Service must include all the details regarding Petitioner's goals/objectives and needs.

First and foremost, past receipt and utilization does not guarantee or promise future benefit allocations. Secondly, the Individualized Plan of Services is the primary document that is utilized to determine current needs. At this time, there is no evidence to indicate the Petitioner's current IPOS needs could not be met in his current setting. Furthermore, if there is an episode of decomposition, the Petitioner can always request additional benefits.

In reviewing cases like these, I can only hold the Department accountable for what they knew or were aware of. In this case, it looks like the documentation did not identify

[8] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2018, pp 77-78.

behavioral needs or a need for care above and beyond what was already required of the licensed AFC home.

As indicated above, based on the evidence presented, the Department's decision was proper and should be upheld as the Petitioner did not meet the medical necessity requirements for additional services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Petitioner's request for CLS services in a licensed AFC home.

IT IS THEREFORE ORDERED that:

The Department decision is AFFIRMED.

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS-Location Contact	Network 180 790 Fuller Avenue NE Grand Rapids, MI 49503
DHHS Department Rep.	Anthony Holston Beacon Health Options Appeals Coordinator Wixom, MI 48393
DHHS -Dept Contact	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913
Authorized Hearing Rep.	[redacted], MI
Petitioner	[redacted], MI