[redacted]
MI [redacted]

Date Mailed: May 15, 2020
MOAHR Docket No.: 20-000553
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on April 14, 2020. [redacted], Petitioner's legal guardian, and Mila Reason, the supervisor at the Adult Foster Care (AFC) facility where Petitioner resides, appeared and testified on Petitioner's behalf. Katelyn Schellenbarger, Supports Coordinator, also testified as a witness for Petitioner. Anthony Holston, Assistant Vice-President of Appeals and Grievances at Beacon Health Options, appeared and testified on behalf of the Respondent Lakeshore Regional Entity. Alyssa Stone, Utilization Review Specialist, and Meghan McNeil, Utilization Management Program Director, from Network 180 also testified as witnesses for Respondent.

ISSUE

Did Respondent properly deny Petitioner's requests for services?

FINDINGS OF FACT

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

1. Petitioner is a [redacted] year-old Medicaid beneficiary with a legal guardian and who has been diagnosed with, among other things, obsessive-compulsive disorder; schizoaffective disorder, bipolar type; dementia; hypertension; irritable bowel syndrome; urinary incontinence; hypothyroidism; osteoporosis; and anemia. (Exhibit A, pages 29-30, 35, 38).

2. She also has a history of falls; memory loss; and difficulties communicating. (Exhibit A, pages 30, 41).

3. For her manic behaviors, Petitioner receives electroconvulsive therapy (ECT) treatments every 2-3 weeks. (Exhibit A, pages 23, 29-30).

4. For her mobility issues, she has also been prescribed a walker, gait belt, and wheelchair. (Exhibit A, page 30).

5. Due to her diagnoses and need for assistance, Petitioner has further been approved for services through Respondent, a Pre-Paid Inpatient Health Plan (PIHP), and one of its associated community mental health services programs (CMHSPs), Network 180. (Exhibit A, page 2).

6. Specific services have included personal care in a licensed setting and Community Living Supports (CLS). (Exhibit A, pages 47-60).

7. The licensed setting is the AFC home where Petitioner has resided for approximately twenty years and where she receives extensive support with mobility, personal care, and her challenging behaviors. (Exhibit A, pages 23, 41-42).

8. Respondent previously paid for the services at a per diem rate based on Petitioner's behavioral level. (Exhibit A, pages 47-60).

9. On October 2, 2019, an Individual Plan of Service (IPOS) meeting was held with respect to Petitioner's IPOS for the upcoming plan year, *i.e.* December 1, 2019 to November 30, 2020. (Exhibit A, page 29).

10. Petitioner's Supports Coordinator then submitted a request to Network 180 for reauthorization of Petitioner's services at the per diem rate. (Testimony of Supports Coordinator).

11. On November 14, 2019, Network 180 denied the request for the reauthorization of services at the per diem rate. (Testimony of Utilization Review Specialist).

12. On December 1, 2019, Petitioner's IPOS was amended at Petitioner's guardian's request due to inaccuracies within it regarding Petitioner. (Testimony of Petitioner's guardian; Testimony of Utilization Review Specialist).

13. Petitioner's Supports Coordinator also submitted a request to Network 180 for the authorization of 91 units of CLS and 17 Personal Care (PC) Points per week for Petitioner. (Testimony of Supports Coordinator; Testimony of Utilization Review Specialist).

14. On December 9, 2019, Respondent received a Local Appeal filed by Petitioner's guardian. (Exhibit A, pages 23-25).

15. The Local Appeal had been signed by Petitioner's guardian on December 3, 2019. (Exhibit A, page 23).

16. In the appeal, Petitioner's guardian stated that the last couple of years have been difficult for Petitioner due to her physical decline, many hospitalizations and near-death experiences, and that the slightest change or disturbance can set her off. (Exhibit A, page 23).

17. Petitioner's guardian also stated that Petitioner needs additional funding to remain in her AFC home, where she has been stable for the past twenty years, in order to avoid trauma and to maintain her level of maximum functioning and quality of life. (Exhibit A, page 23).

18. That same day, December 9, 2019, Network 180 sent Petitioner's guardian a Notice of Benefit Determination regarding the request for 91 units of CLS and 17 PC Points per week. (Exhibit A, pages 26-28).

19. In that notice, Network 180 stated that Petitioner's request was denied, and that only 81 CLS units and 20 PC Points per week would be approved, because the requested amount, scope or duration of services was not clinically appropriate or medically necessary to meet Petitioner's needs. (Exhibit A, pages 26-28).

20. On January 8, 2020, Respondent sent Petitioner's guardian a Notice of Appeal Denial in response to the Local Appeal request received on December 9, 2019. (Exhibit A, pages 3-23).

21. In that notice, Respondent stated that Petitioner's appeal of the denial of an additional ten (10) units of CLS was denied because the units were not clinically appropriate or medically necessary to meet Petitioner's medical needs. (Exhibit A, pages 3-5).

22. Respondent never reviewed the denial of the request for reauthorization of services at the per diem rate as part of the Local Appeal review. (Testimony of Respondent's representative).

23. On January 29, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner's guardian in this matter.

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).

Here, as discussed above, Petitioner has been receiving both personal care in a licensed setting and CLS through Respondent. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS**
>
> Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI 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

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan 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.

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.

* * *

17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/19]

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 (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 children and youth (revised 7/1/19) 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, 2019 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 78-79, 132-133
(Internal highlighting omitted)

While personal care in a residential setting and CLS are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

> **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, October 1, 2019 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 14-15

Here, Respondent and Network 180 denied both Petitioner's initial request for reauthorization of Petitioner's services at the per diem rate and Petitioner's subsequent request for the authorization of 91 units of CLS and 17 PC Points per week on the basis that the amount, scope or duration of the requested services were neither clinically appropriate nor medically necessary. Respondent and Network 180 instead approved 81 CLS units and 20 PC Points per week of services.

Petitioner has appealed those decisions and, in doing so, bears the burden of proving by a preponderance of evidence that the Respondent erred in deciding to deny the requested services. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies, the undersigned Administrative Law Judge finds that Petitioner has met her burden of proof wand that the Respondent's decisions must therefore be reversed.

As a preliminary matter, the undersigned Administrative Law Judge would first note that Respondent erred by failing to address the denial of Petitioner's request for reauthorization of services at the per diem rate as part of the Local Appeal. 42 CFR 438.402 requires that PIHPs like Respondent have a grievance and appeal system in place and that such a system include one level of appeal for enrollees, which Petitioner does have, and which Petitioner's guardian utilized by filing a Local Appeal. Moreover, given the date that appeal was signed and submitted, it could only be addressing the denial of the request for reauthorization of Petitioner's services at the per diem rate. However, as testified to by Respondent's representative and clearly provided in the Notice of Appeal Denial, Respondent only addressed the denial of an additional ten units of CLS as part of its appeal review.

In most cases, the failure to complete the appeal process would mean that a request for

hearing is premature, as pursuant to 42 CFR 438.402(c)(1)(i) and 42 CFR 438.408(f)(1), an enrollee such as Petitioner may typically only request a State fair hearing after filing such an appeal with Respondent and receiving notice that Respondent was upholding that determination. However, both 42 CFR 438.402(c)(1)((i)(A) and 42 CFR 438.408(f)(1)(i) also provide that an enrollee will be deemed to have exhausted Respondent's appeals process, and that she may initiate a State fair hearing, where Respondent fails to adhere to the notice and timing requirements of 42 CFR 438.408 and that is what occurred in this case given Respondent's error.

Respondent was, given its earlier error, also unprepared to address the denial of Petitioner's request for reauthorization of services at the per diem rate during the hearing in this case and it offered no support for that decision, beyond testimony that each assessment stands on its on and that the mere fact that Petitioner was approved for a per diem rate in the past does not mean that she will be approved again in the future.

In contrast, Petitioner's guardian and the supervisor at the AFC facility where Petitioner resides specifically and credibly testified about Petitioner's increased needs as she has declined over the past few years and the need for the same amount of services at the very least; and, given the lack of evidence to the contrary, the undersigned Administrative Law Judge finds that Petitioner has met her burden of proof and that Respondent's decisions must therefore be reassessed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that, while Respondent erred when denying Petitioner's requests for services.

IT IS THEREFORE ORDERED that:

- Respondent's decision is **REVERSED,** and it must initiate a reassessment of Petitioner's requests for services.

Steven Kibit

SK/sb

Steven Kibit
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
48561 Alpha Drive, Suite 150
Wixom, MI
48393

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
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