[redacted]
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Date Mailed: August 10, 2020
MOAHR Docket No.: 20-002317
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 *et seq*; 42 CFR 438.400 *et seq*; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on June 11, 2020. Jennifer VanderMark, Attorney, The Arc of Macomb County, Inc, represented the Petitioner. [redacted] brother and Guardian, and Ann Yuker, Support Coordinator, appeared as witnesses for Petitioner. Leslie Garrisi, Supervisor, represented the Respondent, Macomb County Community Mental Health (CMH).

During the hearing proceedings, the CMH Hearing Summary packet was admitted as Exhibit A, pp. 1-98, Petitioner's additional documentation was admitted as marked, Exhibits 1 and 2.

ISSUE

Did Respondent properly reduce Community Living Supports (CLS) for 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 [redacted]-year-old Medicaid beneficiary, date of birth August 18, 1980. (Exhibit A, p. 12)

2. Petitioner has multiple diagnoses including: intractable headaches, blindness, pseudobulbar affect, generalized anxiety disorder, post-traumatic stress disorder (PTSD), mild intellectual disability, and social anxiety disorder. (Exhibit A, pp. 19 and 37; Exhibit 1, p. 4)

3. An April 24, 2018, neurobehavioral status exam documented additional diagnoses including paranoid schizophrenia, visual hallucinations, auditory hallucinations, other hallucinations, major depressive disorder, acute stress reaction, as well as irritability and anger. (Exhibit 2, p. 3)

4. Petitioner resides in a private residence with his girlfriend, who is also disabled and receives CMH services. (Exhibit A, pp. 12-13 and 21)

5. Prior to March 2019, Petitioner was receiving 42.5 hours of CLS per week. (Exhibit A, p. 1)

6. In March 2019, a temporary increase to 91 hours per week was authorized to allow for additional skill acquisition and safety training. (Exhibit A, p. 1; Supervisor Testimony)

7. Petitioner was also receiving 27.5 hours of skill-building per week. (Exhibit A, p. 2)

8. Petitioner receives Home Help Services (HHS) through the Department of Health and Human Services (DHHS). As of January 17, 2018, Petitioner received 27 hours and 9 minutes of HHS per month. (Exhibit A, p. 72)

9. On December 6, 2019, an Annual Assessment was completed. (Exhibit A, pp. 12-45)

10. On January 23, 2020, a Person-Centered Plan (PCP) Meeting was held. In part, the IPOS listed goals, objectives, and interventions relating to CLS services. (Exhibit A, pp. 46-65)

11. On February 14, 2020, a request was made for 91 hours of CLS per week for Petitioner for the date range March 1, 2020, through August 31, 2020. This was a request to continue CLS at a higher volume for an additional 6 months (Exhibit A, p. 1)

12. On February 20, 2020, the Access Center approved a reduced amount of CLS, 62.5 hours per week, for the same date range because the increased volume of CLS was not supported. (Exhibit A, p. 1)

13. On February 20, 2020, a Notice of Adverse Benefit Determination was issued to Petitioner stating the request for 91 hours of CLS per week was reduced to 62.5 hours per week because a review of the relevant documentation did not show that there had been any substantial clinical changes in Petitioner's diagnosis, abilities, limitations, or needs. (Exhibit A, pp. 5-11)

14. On April 14, 2020, and May 12, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's requests for hearing contesting the determination. (Hearing Requests)

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 1396(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

With respect to CLS services, the Medicaid Provider Manual (MPM) provides in part:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
> - laundry
> - routine, seasonal, and heavy household care and maintenance

- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in

> school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
>
> *MPM, January 1, 2020 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services*
> *Pages, 132-133*

While CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. The Medicaid Provider Manual (MPM) sets forth the criteria for medical necessity and for authorizing B3 Supports and Services:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **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 costeffective 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, Behavioral Health and Intellectual
and Developmental Disability Supports
and Services Chapter,
January 1, 2020, pp. 14-15

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;
- 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.

MPM, Behavioral Health and Intellectual
and Developmental Disability Supports
and Services Chapter,
January 1, 2020, p. 130

Prior to March 2019, Petitioner was receiving 42.5 hours of CLS per week. (Exhibit A, p. 1) In March 2019, a temporary increase was authorized to allow for additional skill acquisition and safety training. (Exhibit A, p. 1; Supervisor Testimony) Petitioner was also receiving 27.5 hours of skill-building per week through Respondent and about 6 hours of HHS per week through DHHS. (Exhibit A, pp. 2 and 72)

On January 23, 2020, a Person-Centered Plan (PCP) Meeting was held. In part, the IPOS listed goals, objectives, and interventions relating to CLS services. (Exhibit A, pp. 46-65)

On February 14, 2020, a request was made for 91 hours of CLS per week for Petitioner for the date range March 1, 2020, through August 31, 2020. This was a request to continue CLS at a higher volume for an additional 6 months. (Exhibit A, p. 1) On February 20, 2020, the Access Center approved a reduced amount of CLS, 62.5 hours per week, for the same date range as the increased volume of CLS was not supported. (Exhibit A, p. 1) The Supervisor testified that the Access clinician for this request was the same clinician that approve the March 209 increase. The Access clinician noted that the increase had been authorized to allow for additional skill acquisition to take place. However, the evidence in the record at the time of the February 2020 determination indicated that Petitioner had gained any skills that he was going to gain. Petitioner was now at a maintenance phase. (Supervisor Testimony) The Supervisor indicated that many of the CLS objectives for CLS in the PCP appeared inflated and were reduced. (Supervisor Testimony) The Supervisor also explained that the temporary increase granted in 2019 was also based on the concerns raised in the April 24, 2018, neurobehavioral status exam that Petitioner was not receiving appropriate treatment services. The additional CLS hours would allow for additional support services while the treatment recommendations were pursued. A lot of the information in Petitioner's records indicated his primary barrier is vision impairment. While CLS would not improve Petitioner's vision, support and assistance could be provided with obtaining more assistive technology, using more applications, or things like that to pursue more independence in those areas. The Supervisor described improvements with self-care, self-direction, and capacity for independent living when comparing 2018 records to the 2020 records. (Supervisor Testimony)

The current PCP has one main CLS goal with 6 objectives, A through F. (Exhibit A, pp. 48-52) Objective A relates to hygiene. The requested 14 hours per week for these activities was reduced to 3 hours per week. Objectives B and D were combined as they relate to activities of daily living, chores, and meal preparation. The requested at least 7 hours per week for objective B and 6 hours per week for objective D were reduced to 3 hours per week total. Objectives C and E were combined as they relate to community activities and interactive play. The requested at least 6 hours per week for objective C and 7 hours per week for objective E were reduced to 8 hours per week total. Objective F related to supervision and safety. The indicated 48.5 hours per week was not changed. (Exhibit A, pp. 48-52; Supervisor Testimony)

The Supports Coordinator went over the reductions to the CLS objectives. The Supports Coordinator did not agree with the reductions and indicated the reduced hours do not allow enough time for Petitioner. Further, Petitioner is not safe if he is left unsupervised. There are concerns that if Petitioner does not retain the 91 hours per week of CLS he will regress when the CLS hours are reduced. In the past when Petitioner's hours are reduced there were increases with anxiety and PTSD symptoms. When the CLS hours were increased they saw progress. The Supports Coordinator believes the requested 91 hours are medically necessary. Regarding other types of assistive technology and adaptive equipment, Petitioner's cognitive impairment prevents him from being able to use or benefit from them. When Michigan Rehabilitation Services was contacted because Petitioner was interested in getting a job, they reached out to the Commission for the Blind, who indicated they did not feel they were able to assist Petitioner. The

Supports Coordinator believes this was due to the cognitive impairments as well as the blindness. Regarding therapy, the family and the Supports Coordinator did not feel that therapy would be appropriate due to Petitioner's cognitive impairment. Regarding safety issues, the family has previously worked on safety skills with Petitioner and reported it has not worked. That is why supervision was requested. (Supports Coordinator Testimony)

Petitioner's brother does not agree with the CLS reduction. There is constant prompting and arguing back from Petitioner to do anything, even when he is not doing something else. Petitioner also has mood swings where a scent or song can trigger rage requiring staff time to re-direct and resolve the situation. Petitioner's visual impairment and related headaches from light were described. The effects of Petitioner's cognitive impairment in combination with the blindness was also described. Petitioner's brother noted prior assistive deceives Petitioner tried as well as responses from several resources for the blind. Petitioner's brother also explained that there are endless safety concerns. Petitioner does not understand the effects of his actions. The history of CLS authorizations was described. Petitioner's hours were steadily increased from 2007-2012. From 2012 to 2017, Petitioner had 91 hours of CLS per week. Then there was an across the board reduction. They have tried to work with Access. Whenever the hours are reduced, Petitioner's regresses. With the proposed reduction there would be hours Petitioner is left alone, there would be entertainment and activities that would be cut, and this would lead to depression. Petitioner would feel more like his life is a prison if he is not able to go out and do what he wants to do. With the 91 hours they have seen improvement as Petitioner had constant staffing and maintained the goal they have been trying to reach. (Brother Testimony)

Given the evidence and applicable policies in this case, Petitioner has not met his burden of proof regarding the CMH's determination to authorize a reduced amount of CLS hours. There is no dispute that Petitioner has substantial care needs. As noted by Respondent, the CLS hours requested for supervision and safety were not reduced. (Supervisor Testimony) Respondent properly considered the other services Petitioner receives, such as skill building and HHS. For example, there were reductions to the CLS hours requested related to chores, meal planning, grocery shopping and meal preparation. (Supervisor Testimony) However, a majority of Petitioner's HHS authorization is for hands on assistance that is also being provided to Petitioner for these activities. (Exhibit A, pp. 71-72) Further, B3 supports and services are not intended to meet all the individual's needs and preferences. This may include preferences for some entertainment activities. Accordingly, Respondent's determination is upheld based on the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly authorized a reduced amount of CLS hours for Petitioner based on the information available.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED.**

CL/dh

Colleen Lack
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

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