[redacted]
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Date Mailed: August 21, 2020
MOAHR Docket No.: 20-003562
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on August 20, 2020. Attorney Simon Zagata appeared on behalf of Petitioner, [redacted] [redacted] Guardian appeared as a witness for Petitioner.

Shawn Dilts, Supervisor of Access, appeared and testified on behalf of Respondent, Shiawasee Health and Wellness (CMH or Respondent). Matt Dohring, Case Coordination Assistant, appeared as a witness for the CMH.

ISSUE

Did the CMH properly suspend Petitioner's Community Living Supports (CLS)?

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, born [redacted] receiving services through Shiawassee Health and Wellness. (Exhibit A, p 7; Testimony)

2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony)

3. On March 23, 2020, Governor Whitmer issued Executive Order 2020-21 regarding: "Temporary requirement to suspend activities that are not necessary to sustain or protect life". In part, that order stated:

To suppress the spread of COVID-19, to prevent the state's health care system from being overwhelmed, to allow time for the production of critical test kits, ventilators, and personal protective equipment, and to avoid needless deaths, it is reasonable and necessary to direct residents to remain at home or in their place of residence to the maximum extent feasible.

This order takes effect on March 24, 2020 at 12:01 am, and continues through April 13, 2020 at 11:59 pm.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. This order must be construed broadly to prohibit in-person work that is not necessary to sustain or protect life . . .

2. Subject to the exceptions in section 7, all individuals currently living within the State of Michigan are ordered to stay at home or at their place of residence. Subject to the same exceptions, all public and private gatherings of any number of people occurring among persons not part of a single household are prohibited.

* * *

3. No person or entity shall operate a business or conduct operations that require workers to leave their homes or places of residence except to the extent that those workers are necessary to sustain or protect life or to conduct minimum basic operations.

    a. For purposes of this order, workers who are necessary to sustain or protect life are defined as "critical infrastructure workers," as described in sections 8 and 9.

* * *

8. For purposes of this order, critical infrastructure workers are those workers described by the

> Director of the U.S. Cybersecurity and Infrastructure Security Agency in his guidance of March 19, 2020 on the COVID-19 response (available here). Such workers include some workers in each of the following sectors:
>
> a. Health care and public health.

4. On March 24, 2020, Petitioner's guardian was informed by the CMH that Petitioner's CLS services would be suspended during the Governor's stay at home order issued in response to the COVID-19 pandemic. (Exhibit A, p 7; Testimony)

5. On March 25, 2020, the Behavioral Health and Developmental Disabilities Administration within MDHHS issued Communication #20-01 regarding Essential Behavioral Health Services and Stay Home Stay Safe Executive Order 2020-21 in the COVID-19 Context. In part, that communication stated:

> This guidance is being issued in response to the Governor's Executive Order 2020-21 (COVID-19) Temporary requirement to suspend activities that are not necessary to sustain or protect life (Stay Home Stay Safe Order) and is directed to Pre-Paid Inpatient Health Plans (PIHPs), Community Health Service Programs (CMHSPs), their provider agencies and direct care workers that provide home and community based behavioral health care and supports or direct care clinical services to individuals with serious mental illness, children with serious emotional disturbance, individuals with intellectual and developmental disabilities, substance use disorders, and all other individuals served by the public behavioral health system or experiencing a behavioral health crisis.
>
> All behavioral health services are essential to sustain and protect life and therefore must continue to be provided under the Governor's Stay Home Stay Safe Order. Behavioral health services shall continue to be provided in homes, residential or clinical settings if such services cannot reasonably be performed telephonically or through other virtual methods and are necessary to sustain and protect life. Home-based or clinic-based services are necessary to sustain and protect life if, based on a provider's good faith clinical

judgment, are necessary for the individual to remain in the least restrictive environment, are required for assistance with activities of daily living, instrumental activities of daily living (IADLs), be sustained on life-preserving medication, as well as those services necessary to maintain behavioral or psychiatric stability.

Essential services that do not require face to face home-based or clinic-based intervention may be done telephonically or through other virtual methods. Each service should be evaluated on an individual basis and the clinical rationale for telephonic or virtual method must be documented. The clinical rationale for the use of virtual methods vs home-based or clinic-based intervention given the Governor's Stay Home Stay Safe Order should be based upon the behavioral health needs of the individual and whether or not a home-based or clinic-based intervention is essential to maintain the individual's health and safety and at home and in the least restrictive environment. The clinical rationale for the use of telephonic or virtual services must be reviewed and updated regularly as the individual's needs and the public health crisis evolves.

* * *

Essential services for which there must be a clear determination of when to deliver a face to face in-person encounter vs a virtual encounter include but are not limited to the following services:

- Community crisis stabilization- 24/7 response
- Pre-admission screening for inpatient psychiatric care
- Inpatient psychiatric care
- Intake and access to care services
- Crisis residential
- Intensive crisis stabilization, via mobile or on-site stabilization

- Community living supports – (limited to supporting independent living needs not socialization)
- Private duty nursing
- Personalized care in specialized residential settings
- Overnight health and safety supports
- Psychiatric services – assessments and medication reviews
- Medication administration
- Assertive community treatment
- Individual and group therapies, including home-based services for children,
- Applied Behavioral Analysis (ABA)
- Case management and supports coordination, including wraparound services
- Substance use disorder withdrawal management
- Substance use disorder residential treatment services
- Medication assisted treatment – Opioid treatment programs and office based opioid treatment services
- Adult Peers, Recovery Coaches, Parent Support Partners and Youth Peer Support Specialists
- Recipient Right services

6. On April 27, 2020, Petitioner's guardian contacted the CMH to inquire as to when services might be reinstated as Petitioner was having a very difficult time and becoming depressed with no services in the home. (Exhibit A, p 8; Testimony)

7. On April 28, 2020, CMH's supervisor checked with the provider to see if they would be able to serve Petitioner. CMH's supervisor was informed

that the provider could not serve Petitioner due to staff shortages. (Exhibit A, p 9; Testimony)

8. On April 29, 2020, CMH informed Petitioner's guardian that the provider had a new staff member that could provide in home CLS two days per week beginning May 11, 2020. Petitioner's guardian chose Mondays and Thursdays. (Exhibit A, p 10; Testimony)

9. On May 19, 2020, Petitioner's guardian inquired as to when CLS would return to the normal schedule and if the current staff (which began May 11, 2020) would be the permanent staff. (Exhibit A, p 12; Testimony)

10. Between May 19, 2019 and June 22, 2019, CMH and Petitioner's guardian communicated regularly regarding staffing Petitioner's CLS. (Exhibit A, pp 13-20; Testimony).

11. On June 24, 2020, Petitioner's provider contacted CMH to inform them that the provider would no longer be able to provide services to Petitioner after July 23, 2020. CMH informed Petitioner's guardian of this news on the same date. (Exhibit A, p 21; Testimony)

12. On June 24, 2020, CMH sent a referral to a new provider agency to see if the new agency could staff Petitioner's CLS hours. (Exhibit A, p 23; Testimony).

13. On June 30, 2020, CMH contacted another provider agency about staffing Petitioner's CLS hours. (Exhibit A, p 26; Testimony)

14. On June 30, 2020, CMH sent Petitioner's guardian a Notice of Adverse Benefit Determination informing her that Petitioner's services would be terminated[1] effective July 23, 2020 due to a lack of service provider. (Exhibit A, pp 2-4; Testimony)

15. On June 8, 2020[2], Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1)

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).

[1] While the first page of the Notice indicates that the services will be Terminated, other portions of the notice refer to a Suspension. Upon information and belief, Petitioner's services were Suspended, not Terminated.

[2] The Request for Hearing predates the Notice of Adverse Benefit Determination because Petitioner was encouraged to appeal CMH's decisions regarding CLS at a prehearing conference held on May 7, 2020 in a related case.

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…

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. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. 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.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.
>
> **2.5.B. DETERMINATION CRITERIA**

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
    - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - experimental or investigational in nature; or
    - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 12-14

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.

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, (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 state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

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

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

events in a park; volunteering; voting)

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

➢ Reminding, observing and/or monitoring of medication administration

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

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

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 120, 122-123
Emphasis added.

CMH's Supervisor of Access testified that while the suspension of Petitioner's CLS initially was due to the Governor's executive order related to COVID-19, the CMH also conducted an individualized assessment of Petitioner's needs and determined that his CLS services were not essential to sustaining and protecting life because all Petitioner's Activities of Daily Living pertaining to sustaining and protecting life were provided by Petitioner's step-father, who is also Petitioner's Home Help provider. CMH's Supervisor of Access testified that the other objectives being met through CLS, including pedestrian safety, cooking safety, and exercise were not always being used by Petitioner. CMH's Supervisor of Access noted that shortly after Petitioner's CLS services were suspended, CMH did allocate some of its own direct care staff to provide Petitioner with CLS in the home given that CLS out of the home was not allowed under the stay at home order. CMH's Supervisor of Access testified that the more recent suspension of CLS services (effective July 23, 2020) was due solely to a shortage of staff/providers.

CMH's Case Coordination Assistant (CAA) testified Petitioner had two provider agencies working in the home and that both eventually had to pull staff out of Petitioner's home due to staffing shortages. CMH's CAA indicated that there has been some progress in finding new staff and he has recently made a referral for an out of

network provider that may be able to meet Petitioner's needs. CMH's CAA testified that there was some information in the Progress Notes about Petitioner refusing services, but it was not every time and it usually occurred around activity based CLS. CMH's CAA admitted that Petitioner had the right to refuse services and that it was written in Petitioner's PCP that staff should not pressure Petitioner if he refused the same service twice.

Petitioner's Guardian reviewed Petitioner's CLS schedule prior to the first suspension and discussed how important the CLS was to Petitioner. Petitioner's Guardian indicated that Petitioner was working on learning sigh language, doing laundry, cleaning, and how to make a bed and Petitioner loved every minute of working with the CLS staff. Petitioner's Guardian testified that Petitioner was always very excited to go into the community with CLS staff. Petitioner's Guardian testified that now, without CLS, Petitioner has become very depressed.

Petitioner bears the burden of proving by a preponderance of the evidence that CMH erred in suspending his CLS. Based on the evidence presented, Petitioner has met that burden, especially with regard to the recent suspension (effective July 23, 2020) that was based solely on staff shortages. The suspension of services initially relating to the COVID-19 pandemic and the Governor's stay at home order is a closer call as it appears that the CMH did conduct an individualized assessment of Petitioner's needs and use of CLS and determined that CLS was not essential to protect life or health. And, while the undersigned may not agree with this conclusion, given that some in-home CLS was reinstated back in April 2020, the point with regard to the prior suspension is really moot at this time. *Michigan Chiropractic Council v. Commissioner of Office of Financial and Ins. Services*, 475 Mich 363, 716 N.W.2d 561 (2006). Given that CLS was provided by an outside agency, Petitioner would have no legally cognizable interest in such an outcome.

Regarding the recent suspension, it is undisputed that the approved CLS services for Petitioner are medically necessary and that the sole reason the services were suspended was because, despite some efforts, CMH has been unable to locate a provider for Petitioner and it lacks the provider capacity to properly serve Petitioner. However, CMH's inability to locate a provider, either in-network or out-of-network for Petitioner's medically necessary services is not a proper basis for a suspension of services. According to 42 CFR 438.206(1), each State must ensure that all services covered under the State plan are available and accessible to enrollees of PIHPs in a timely manner and that each PIHP maintains and monitors a network of appropriate providers that is both supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees. Moreover, 42 CFR 438.206(4) states that, if the provider network is unable to provide necessary services covered under the contract to a particular enrollee, the PIHP must adequately and timely cover these services out of network for the enrollee, for as long as the PIHP is unable to provide them.

Accordingly, given the undisputed medical necessity for the approved services and the lack of any valid basis for suspending them, Respondent erred in suspending Petitioner's CLS services and its decision must be reversed.

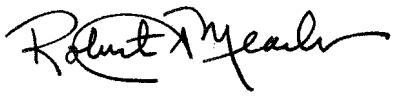
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly suspended Petitioner's CLS services due to lack of providers.

IT IS THEREFORE ORDERED that:

The CMH decision is REVERSED.

Within 10 days of the issuance of this Order, Respondent must certify that it has reinstated Petitioner's CLS services. Respondent must also continue to seek a provider for those services, either in-network or out-of-network.



RM/sb

Robert J. Meade
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 Department Rep.

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