GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
DIRECTOR

[redacted]

Date Mailed: April 25, 2024
MOAHR Docket No.: 24-002785
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 hearing was held on April 23, 2024. [redacted] Petitioner's parent and guardian appeared and testified on Petitioner's behalf. [redacted] parent and guardian; Heather Reamon, Home Manager, Terrace Park; Brianna Hartman, Activity Lead, Terrace Park; Kaela Bucholtz, Healthcare Lead, Terrace Park; Delissa Payne, Area Director, Spectrum Community Services; Jordan Walch, Associate Director, Spectrum Community Services; and Rebecca Mueller, Supports Coordinator, Network 180, appeared as witnesses for Petitioner.

George Motakis, Fair Hearing Officer, Lakeshore Regional Entity, appeared and testified on behalf of Respondent, Network 180. (CMH or Department). Julie Minor, Utilization Review Specialist and Mehgan McNeil, Associate Director, Utilization Management, appeared as witnesses for the CMH.

ISSUE

Did the CMH properly deny Petitioner's request for continued Personal Care (PC) and Community Living Supports (CLS) in a Specialized 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 an adult Medicaid beneficiary who is eligible to receive services through the CMH. (Exhibit A; 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. Petitioner currently resides at Terrace Park Adult Foster Care (AFC) home, which is a specialized residential setting. (Hearing Summary [HS]; Exhibit A; Testimony.)

4. Petitioner is diagnosed with severe intellectual disability, Jacobsen Syndrome, Vater Syndrome, morbid obesity, and anxiety disorder. (HS; Exhibit A; Testimony.)

5. Petitioner attended Lincoln School Development Center until May 2022, when she aged out of the program. (HS; Exhibit A; Testimony.)

6. On March 8, 2022, Petitioner was referred to CMH for a behavioral assessment to address target behaviors, including physical aggression, incontinence, and self-injurious behaviors. (HS; Exhibit A; Testimony.)

7. Following the assessment, Petitioner was authorized to receive PC and CLS services at the Base Residential rate to address these target behaviors, which allowed her to reside in a Specialized Residential setting. (HS; Exhibit A; Testimony.)

8. From March 28, 2022, to May 8, 2023, Petitioner's targeted behaviors improved, according to a behavioral assessment conducted on May 8, 2023 by Sparks Behavioral Services. (HS; Exhibit A; Testimony.) The data collected for the assessment showed the following incidents of targeted behaviors:

Date	SIB	Incontinence
August 2022	0	1
September 2022	2	1
October 2022	6	0
November 2022	0	0
December 2022	1	0
January 2023	9	1
February 2023	0	0
March 2023	0	0
April 2023	0	0

(*Id*.)

9. Following the May 8, 2023, assessment, Sparks Behavioral Services concluded that Petitioner had met her behavioral objectives; and they discontinued their services. (HS; Exhibit A; Testimony.) Staff at

Petitioner's AFC home continued to utilize preventative strategies to help maintain Petitioner's progress. (*Id*.)

10. There was no further documentation of behavioral issues for Petitioner after May 8, 2023. (HS; Exhibit A; Testimony.)

11. On February 1, 2024, following a utilization review, CMH sent Petitioner's parents a Notice of Adverse Benefit Determination, denying continued CLS and PC at the Base Residential rate. (Exhibit B; Testimony.) Specifically, the Notice indicated, in relevant part:

> The clinical documentation provided does not establish medical necessity.
>
> You have Base Behavior rate for PC and CLS to help with behaviors like hurting yourself. You have been doing very well with this for a long time, and you no longer need Base Rate. Your Supports Coordinator should ask for Light Residential rate. Please contact the Supports Coordinator with questions. This is based on the Michigan Medicaid Provider Manual and Network 180 PC/CLS Guidelines.

(*Id*.)

12. On February 22, 2024, following a local appeal, Petitioner was sent a Notice of Appeal Denial, which indicated in relevant part:

> Your Internal Appeal was denied for the service/item listed above because:
>
> You requested a review of the decision to reduce your daughter's level of care from base residential rate to light residential rate. Your case was reviewed and [redacted] reports have been improved over the past year, including not needing a behavior plan anymore. Her data shows her behaviors are very minimal and this qualifies her rate to be adjusted. Your appeal has been denied.

(Exhibit D; Testimony)

13. On March 20, 2024, 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). 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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with MDHHS 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 applicable sections of the Medicaid Provider Manual (MPM) provide:

> **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.

* * * *

17.2 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF BEHAVIORAL HEALTH 1915(I) STATE PLAN AMENDMENT (SPA) SUPPORTS AND SERVICES [RE-NUMBERED, TITLE REVISED & CHANGES MADE 4/1/23]

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by BH 1915(i) SPA supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to ensure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether BH 1915(i) SPA supports and services alone, or in combination with State Plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in their community; and without such services and supports, would be impossible to attain.

* * * *

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. (Emphasis added)

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*
> *July 1, 2023, pp 90-91; 145-146; 12-14*
> *Emphasis added*

Petitioner must prove, by a preponderance of the evidence, that she meets the above medical necessity criteria for Personal Care and Community Living Supports (CLS) in a Specialized Residential setting, i.e., those services at the Base Residential rate.

Petitioner's AHR argues that Petitioner meets the medical necessity criteria for Personal Care and Community Living Supports (CLS) in a Specialized Residential setting because her behaviors have not actually improved to the extent noted in the May 8, 2023, assessment; and this is only a matter of lack of documentation. Petitioner argues that she has done better in her current setting because of the setting, and to remove her would be detrimental. Petitioner's AHR indicated that there were lots of reasons for the lack of documentation, including a change in management at the home, but that the behaviors are continuing. Petitioner's AHR argues that Petitioner requires 24/7 awake staff, and that type of staffing is not available in a regular AFC home. Petitioner's AHR argues that while no incidents of targeted behaviors have been documented since May 8, 2023, the behaviors are recorded in the progress notes.

CMH argues that Petitioner does not meet the medical necessity criteria for Personal Care and Community Living Supports (CLS) in a Specialized Residential setting because there are no documented incidents of targeted behavior since May 2023. CMH argues that no one from Petitioner's AFC home or her parents contacted CMH to alert them to Petitioner's improved behaviors, and CMH only discovered this during an annual assessment. CMH argues that based on the clinical documentation available for review, Petitioner's needs can be met in a regular AFC home, i.e., at the Light Residential rate.

Having considered the parties arguments in full, it is determined that Petitioner has failed to meet her burden of proof, and therefore, the CMH properly denied her request for continued Personal Care and Community Living Supports (CLS) in a Specialized Residential setting.

Under Medicaid's medical necessity criteria, there exists a more clinically appropriate, less restrictive, and more integrated setting in the community for Petitioner. Specifically, given the evidence presented, Petitioner's needs can be met in a general AFC home, with PC and CLS assistance through the CMH.

As indicated above, Personal Care and Community Living Supports (CLS) in a Specialized Residential setting are only authorized when a beneficiary's needs are "beyond the level required by facility licensure." Here, Petitioner was receiving Personal Care and Community Living Supports (CLS) in a Specialized Residential setting for the targeted behaviors of incontinence and self-injurious behaviors. However, as indicated above, there is no documentation of those behaviors occurring since May 8, 2023. For the CMH to determine that Petitioner's needs are "beyond the level required by facility licensure," it needs documentation of the targeted behaviors that led to Petitioner's placement in the first place. Here, of course, there is no documentation of any targeted behaviors since May 8, 2023.

Furthermore, policy provides that "goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by BH 1915(i) SPA supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to ensure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. Here, again, Petitioner was receiving Personal Care and Community Living Supports (CLS) in a Specialized Residential setting for the targeted behaviors of incontinence and self-injurious behaviors. However, as indicated above, there is no documentation of those behaviors since May 8, 2023.

Petitioner's arguments to the contrary are not persuasive. While there may have been good reasons for a lack of documentation of Petitioner's target behaviors, CMH may only base a utilization review on the documentation provided to it.

As indicated at the hearing, if Petitioner's target behaviors have continued, Petitioner's AHR needs to present documentation of same to Petitioner's supports coordinator and request an updated review of Petitioner's needs. However, based on the evidence available to the CMH at the time of the decision, that decision was proper.

Petitioner bears the burden of proving by a preponderance of the evidence that Personal Care and Community Living Supports (CLS) in a Specialized Residential setting are a medical necessity in accordance with the Code of Federal Regulations (CFR) and Medicaid policy. Petitioner did not meet the burden to establish that such services are a medical necessity.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner's request for Personal Care and Community Living Supports (CLS) in a Specialized Residential setting.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED.**

RM/pe

Robert J. Meade
Administrative Law Judge

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

Via Electronic Mail:

DHHS Department Contacts

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