STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[redacted]

Date Mailed: June 12, 2024
MOAHR Docket No.: 24-005023
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 June 11, 2024. [redacted] Petitioner's parent, and guardian appeared and testified on Petitioner's behalf. [redacted] Petitioner, appeared as a witness.

Stacy Coleman, Fair Hearing Officer, appeared and testified on behalf of Respondent, Macomb County Community Mental Health. (CMH or Department).

ISSUE

Did the CMH properly deny Petitioner's request for 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 is authorized to receive Assertive Community Treatment services. (Exhibit A; Testimony.) Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes

case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

4. In early 2024, Petitioner requested authorization for PC and CLS in a Specialized Residential setting. (Exhibit A; Testimony.)

5. On February 20, 2024, following a utilization review, CMH sent Petitioner a Notice of Adverse Benefit Determination, denying CLS and PC in a Specialized Residential setting. (Exhibit A, pp 2-7; Testimony.) Specifically, the Notice indicated, in relevant part:

> Your request for Community Living Supports and Personal Care in Licensed Specialized Residential has been denied. Based on what was reported in the staff planning guide and with the information in your clinical chart, it was decided that you do not need the level of assistance with your community living tasks and your personal care to need this level of care.
>
> (*Id*.)

6. On February 28, 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 asked for Personal Care in a Specialized Residential and Community Living Supports so that you could move to a Specialized Residential home *Rose Hill). After looking over your plan of service, progress notes and meeting with your treatment team, it was decided that you do not meet the medical necessity criteria for Personal Care in a Specialized Residential. These were new requests and have not been approved before.
>
> (Exhibit A, pp 9-14; Testimony)

7. On May 10, 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
January 1, 2024, pp 90-91; 145-146; 12-14
Emphasis added

Petitioner must prove, by a preponderance of the evidence, that he meets the above medical necessity criteria for PC and CLS in a Specialized Residential setting.

Petitioner's mother/guardian testified that last year Petitioner was going to clubhouse and had found a place to live, but he was totally unable to deal with it and had to smoke pot to function. Petitioner's mother/guardian indicated that Petitioner was saying all the right things, but was crumbling, and by fall of 2023 he was not functioning at all. Petitioner's mother/guardian testified that Petitioner went to a substance abuse treatment center but they called and told her he had to leave because of the severity of his mental health problems. Petitioner's mother/guardian indicated that they brought Petitioner back into the family home but all he does is sleep constantly. Petitioner's mother/guardian testified that Petitioner is so overwhelmed by his mental illness and autism spectrum disorder that he cannot function.

Petitioner's mother/guardian noted that Petitioner cannot cook his own meals, cannot make his own phone calls, or keep track of important papers, such as those needed to keep his Medicaid eligibility. Petitioner's mother/guardian indicated that even getting him to participate in this phone hearing was a struggle. Petitioner's mother/guardian testified that if she does not cook for Petitioner, he does not eat.

Petitioner's mother/guardian testified that Petitioner has been with ACT for four years. Petitioner's mother/guardian noted that Petitioner has had 5-6 case managers and at least 3 psychiatrists. Petitioner's mother/guardian testified that only one therapist was successful with Petitioner and she left. Petitioner's mother/guardian noted that Petitioner has only had one session of EMDR in the past year because CMH cannot find anyone to help him. Petitioner's mother/guardian testified that Petitioner has been hospitalized 20 plus times in the past few years so clearly he is not getting the help he needs. Petitioner's mother/guardian indicated that Petitioner needs a secure environment where he can receive therapy every day and start to make baby steps towards getting better. Petitioner's mother/guardian testified that the persons at the facility they want to send Petitioner are just like him and the facility has a contract with CMH.

Petitioner's mother/guardian testified that Petitioner is a good person, but just overwhelmed and does not understand the world. Petitioner's mother/guardian indicated that Petitioner is prescribed intense psychiatric medication and must go to CMH for a blood test every week and meet with the psychiatrist for a medication review every two weeks. Petitioner's mother/guardian testified that she wants Petitioner to learn to live independently and the facility they found can help him do that. Petitioner's mother/guardian indicated that it's not a choice that Petitioner does not perform his own personal care, it is due to his mental illness. Petitioner's mother/guardian indicated that Petitioner's executive functioning is very low, but his verbal skills are off the chart, so he presents as very intelligent but his abilities are really limited.

Petitioner testified that going to the facility his family found would be very beneficial for him, more beneficial than an AFC home.

CMH argues that Petitioner does not meet the medical necessity criteria for PC and CLS in a Specialized Residential setting because Petitioner is able to take care of his own personal care tasks and a Specialized Residential setting is not the least restrictive environment that can meet Petitioner's needs.

Having considered the parties arguments in full, it is determined that Petitioner has failed to meet his burden of proof and, therefore, the CMH properly denied the request for PC and 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 with continued Assertive Community Treatment services.

As indicated above, PC in a Specialized Residential setting is only authorized to "assist a beneficiary in performing their own personal daily activities." Here, Petitioner is fully independent with all his Activities of Daily Living (ADL's) and needs no assistance to perform those activities. And, while Petitioner often chooses not to engage in these activities, he is able to do so with prompting and reminding, something that can easily be provided in an AFC home. Further, Petitioner can learn to live more independently while in an AFC home with CLS services through CMH, which can help him learn to prepare meals, for example, which was one of the goals in his latest IPOS. Petitioner would also continue to receive the high level of services that he is already authorized to receive through Assertive Community Treatment.

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, an AFC home is a less restrictive environment than a Specialized Residential setting and Petitioner's needs can be met in an AFC home.

As indicated at the hearing, Petitioner can request another review of his services at any time. 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/sj

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 12th day of June 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via First Class Mail:

Petitioner
[redacted]

Authorized Hearing Representative
[redacted]

Via Electronic Mail:

DHHS Department Contact
Belinda Hawks
MDHHS-BHDDA
Lansing, MI 48913
MDHHS-BHDDA-Hearing-Notices@michigan.gov

DHHS Location Contact
Macomb County CMHSP
Clinton Township, MI 48036 24-005023
Mfhcorrespondence@mccmh.net