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Ann Braford's Story about her brother

Here are some of the challenges that I have faced with my brother, as the Utilization Management (U.M.) at Network 180 has reduced his level of care.

I have attached the letter I sent in with my Level One Appeal from the Notice of Benefit Determination that I received on November 18, 2019 and the Notice of Benefit Determination so that you can see how abstract it is to the guardian, who knows very little about how the system works. How do you defend against a statement that says: *The service, or the amount, scope or duration of services identified in this notice are not clinically appropriate, or medically necessary, to meet your needs or consistent with your diagnosis, symptoms or impairments, or the most cost effective options in the least restrictive environment, or consistent with the current/clinical standards of care.*
Which is it? Not clinically appropriate? Not medically necessary? Not consistent with your diagnosis or symptoms of impairments? Etc.

I personally believe that it all falls on *consistent with the current/clinical standards of care* that Network 180 once again has changed. I have found no documentation or policies that define level of care. I have *heard* from several Supports Coordinators that what has changed is the 'units' or hours of care needed for each level of care.

The other issue that I would not have known if David's provider had not shared it with me is that they received the authorization on 11/13/2019, but the authorization effective date was 10/1/2019.
I have also attached that authorization notice so you can see what they wrote to the provider. It is not the individuals or the providers fault that the PCP was not scheduled in time to meet his IPOS end of year date – it was because of the transition of moving the supports coordination in house so why wouldn't the effective date be 12/1/1019? And the provider did not receive adequate notice of the payment reduction.

The other issue that I don't understand is how an individual can only receive up to 4 points in areas of personal care. Which is outlined in Network 180 Personal Care in a Licensed Setting / Community Living Supports Guidelines that is given to the supports coordinators to help them write the Personal Center Plan and then recommend to the U.M. the services needed.
So for Personal Care Task they are to consider – the type of assistance needed.
0 – None
1 – Monitoring (needed due to resistance or health and safety)
2 – Verbal/gesture prompt (needed due to resistance or health and safety)
3 – Partial Physical Assistance
4 – Full Physical Assistance

So for bathing, toileting, dressing all these areas of personal care assistance gets a number – and it really doesn't capture the amount of time, scope or duration that it is supposed to capture to really meet the need of the individual. There are also no goals attached to these areas. And because it is not detailed and just given a number – my brother for instance is a 4 in all those areas – so he caps out at a 4 – with the $ amount that goes with that number. If you look at the Network 180 authorizations you will see a pretty low dollar amount in personal care T1020. David's T1020 = $43.00 (this years) last year at Medium Medical he was receiving T1020 - $45.04. And the H2016 CLS is always the higher funded amount. If you look at other counties the opposite is true. (Summit Point T1020 = $137.81, H2016 = $19.84) (Genesee – T1020 = $77.50, H2016 = $77.50) these are from 2 individuals authorizations that we serve that are out of Kent County. So how does the point system in Personal Care really show the true support needed for an individual that is severely physically handicapped?

The U. M. at Network 180 also do not take into account prior authorizations. David has been receiving a daily rate of Medium Medical since 2014. So all of a sudden he got better so now all the services he is receiving, even though we added 2 more exceptions during this last year - it is most appropriate for him to receive a daily rate of Low Medical?

With Network 180 the Providers rate of reimbursement is not only in a tiered level of care system – but then is also determined by how many beds in the home. So the Medicaid funding does not follow the person – it depends on where they choose to live. My brother lives in a 12 bed licenses home, has his

own private bedroom and bathroom and receives a Low Medical daily rate of $106.57. (Which we are appealing) if he lived in a 6 bed licensed home he would receive a daily rate of $168.00. All the care expectations are the same in both size homes – so how can the daily rate be deducted based on beds if the medical necessity and supports needed are the same?

Other issues that need to be addressed.

Providers are not receiving 30 day notice of reduced funding AND when services are reduced for an individual there is nothing on the authorization form that informs the provider which services/supports in the IPOS they are not authorizing – so the provider doesn't truly know what services they are no longer getting reimbursed to provide. We are seeing that the U.M. is using a general statement that says 'this is within the guidelines of AFC expectations', but for the last several years they were not?

Just lately I have been advocating with the other guardians at David's House to ask for an Independent facilitator to represent them during the Personal Planning Process. I had an Independent Facilitator at my brothers planning meeting and it was the first time in a long time that we actually had a pre-planning meeting (meaning they were not isolated meetings) and the first time that I felt that David was truly engaged in the process. This is important to me especially since Network 180 pulled the supports coordinators in house AND the U.M. is in the same house. That seems to be a conflict of interest to me, especially since they are carrying a deficit. Let alone the deficit of the LRE. Looks a lot like reductions of services based on their budget issues.

The other thing that I have been advocating for is that once the IPOS is written I think that the guardian should be able to read through it before it is sent in to the U.M. to be authorized. Now the IPOS is written and turned in to U.M. and then it is sent back to the guardian to sign. If services are limited or reduced you still have to sign but now you get to file the Level One Appeal, when just maybe the guardian or Independent Facilitator may have caught something that the supports coordinator may have missed, or maybe the language was not descriptive enough. The couple of times this has been requested the supports coordinator don't know what to say or they say they I don't know if I can send it to the guardian first – that's not how we have done it.

I would like to see the wage pass thru as a line item on the authorization sheet. We receive an increase for the rest of that contract year for the wage pass through and then the new IPOS get filed and authorized and services are reduced by $1.23 from last year. What unit was not authorized and where did the increase from the wage pass through go? If the wage pass thru was $2.50 added to the daily rate and they are reduced by $1.23 the following year was the reduction really $3.73 in services so that the total reduction was just $1.23?

One of the most frustrating things I have seen this year (2019) – because Network180 is 'right sizing' that is what they say when they refer to the role of the U.M. I know of 5 guardians that filed Level – One Appeals. One won their appeal – 3 lost their appeals and 1 is still pending. 2 of them went on to file for a Medicaid State Fair Hearing. In order to represent themselves appropriately they hired a coach to help them through this process. (out of pocket cost of $500-600) Then the decision can back from the State Fair Hearing that they were denied. I would think that at that level of hearing you would want to present documentation to show your reasons for appealing. Like a new SIS, maybe a letter from your Doctor etc. But you are denied not because you didn't provide necessary information BUT because Network 180 did have that same information available to them. Really? Why would you go to the next level of hearing if the new documentation is not weighted? Now I can see that they would not have to go back and make a retro payment for those services but if the evidence is there to show the services/supports are needed then give them back the services that were reduced or limited effective the date of the decision. Again it is not fair to the individual or the provider that Network 180 is system wide was behind on completing the SIS. It isn't the guardian's or individuals fault that the supports coordinator didn't look to see if a nursing assessment has been completed within the last couple of years. All valuable parts to having a true person centered plan. Unfortunately the supports coordinators are finding their way through the system changes and what language the U.M. is looking for just as the guardians are. I had a supports coordinator comment to me about how undermined they felt. They build the relationship with the individual, write the IPOS so that that individual can be supported and have the necessary services for their health and safety needs and then the U.M. just disregards their recommendations and reduces

services that they truly felt were needed. Why doesn't the U.M. communicate with the supports coordinator? Ask questions? I personally have brought this up to Network 180 several times in different meetings. It truly depends on how well your supports coordinator can write in detail crafting the IPOS with the right language in order to get services authorized. The IPOS is the most important contract/ document that an individual has – it alone outlines the services and goals needed not only for their health and safety but to be engaged in life. It would seem to me that supports coordination training would be a top priority for all CHMS. AND it should be the same through the region! I thought that was what the regions were designed for – to help the individual and the providers make seamless transitions throughout the counties. Fewer inspections, reviews, the same training requirements (that may be the only one they really did) the same contract language for providers, etc. a more efficient way of providing services for the most vulnerable individuals.

Thank you

Ann Braford

network180

Notice of Benefit Determination

DATE: 11/18/2019 **NAME:** DAVID L. DEBOER **Birthdate:** 11/23/1956 **Case #:** 026338

Provided Notice To:

REV JAY & LOIS DEBOER
2105 Raybrook Street Se
#3034
Grand Rapids, MI 49546

Attached Local Appeal form

Notice has been provided
☐ In Person ☒ Via Mail

Notice Provided On
11/18/2019

This is to notify you that we have made the following decision(s) about the service(s) you have asked for or about the service(s) you receive. The legal basis for this decision is 42 CFR 440.230 (d); the Michigan Mental Health Code; Act 258 of the Public Acts of 1974 as amended; and/or the Medicaid Provider Manual. The action being taken is:

Action Taken

☒ Adequate Notice (at the time of action)	Service(s) Affected
☒ Denial or limited authorization of a requested service (including type or level of service	Personal Care, CLS Requested Medium Medical daily level of care
☐ Denial, in whole or in part, of payment for a service	
☐ Failure to provide services within 14 calendar days of the agreed upon start date	
☐ Failure to make an authorization decision within the required time frames	
☐ Failure to act on a local appeal within the required time frames	
☐ Failure to provide disposition of a grievance within 90 calendar days	
☐ Administrative discontinuation of services	

Reason For Action

☑ The service(s), or the amount, scope or duration of service(s) identified in this notice are not clinically appropriate, or medically necessary, to meet your needs, or consistent with your diagnosis, symptoms or impairments, or the most cost effective option in the least restrictive environment, or consistent with current/clinical standards of care.

☐ Your Individual Plan of Service goals and objectives have been met.

☐ We cannot continue to authorize services for you if you are not participating in treatment.

☐ You do not meet clinical eligibility criteria for services as:

- ☐ A person with a serious mental illness
- ☐ A person with an intellectual / developmental disability
- ☐ A child with a serious emotional disorder
- ☐ A person with a substance use disorder

☐ You are currently in an instituion where we cannot authorize services (e.g. jail, prison, state hospital, extended care facility)

☐ Your Medicaid Health Plan is responsible for providing services to you.

Please contact your Health Plan:

Phone Number:

☐ You no longer have Medicaid coverage. If you believe you still need services,

please contact:

to request general fund services. Please note that individuals who do not have Medicaid may be placed on a waiting list.

☐ You have voluntarily requested termination of your services.

☐ Other:

Recommended Services/Supports

Approved Low Medical daily level of care

Signatures

Utilization Management LMSW 11/18/19

STAFF SIGNATURE / CREDENTIALS DATE

January 14, 2020

Beacon Health Options
Attn: Grievance and Appeal Coordinator
48651 Alpha Dr. Suite 150
Wixom, MI 48393

RE: Letter stating my disagreement with the Adverse Benefit Determination dated November 18, 2019 for David L DeBoer, Network 180 Case # 026338.

To Whom it May Concern:
I, Jay DeBoer, Guardian and Ann Braford, Co-Guardian of David DeBoer disagree with the Adverse Benefit Determination that states that the requested Medium Medical daily level of care is denied or limited to Low Medical daily level of care for the following reasons.

There is nothing specific listed in the Notice of Benefit Determination to give documented support for the reduction of level of care. David's personal care and CLS needs have not improved nor has his diagnosis changed or improved over the past year, or years. In fact, there were 2 more treatment guidelines added to his IPOS (which my Provider told me were noted as exceptional medical needs). These 2 treatment guidelines are in addition to the services that have been authorized as Medium Medical since 2014. According to 2.5.D PIHP Decisions, that a PIHP may employ various methods to determine amount, scope and duration of services, including *prior authorizations* for certain services, concurrent utilization management reviews, ... I would ask that David's prior authorized Medium Medical daily level of care be taken into consideration. Without any service reductions noted in his IPOS or in the Adverse Benefit Determination and with 2 new treatment guidelines added to this year's IPOS, I don't understand how there can be a level of care reduction when obviously David's needs have not improved. The recommendation by his Supports Coordinator for Medium Medical daily level of care is the most appropriate level of care. This reduction in his daily rate could jeopardize his AFC placement.

Since there is no description of what differentiates the various daily levels of care, and without specific service reductions or parameters that describe the various daily rate levels of care given to determine which daily level of care is appropriate, I am at a loss as to how to defend against this reduction. So, to help support why David's Medium Medical daily level of care is the most appropriate, I have attached 3 treatment guidelines for clarification of interventions that are already being implemented from the Social Work Assessment. 1) Safe Use of Motorized Wheelchair 2) Spastic Quadriplegia Infantile Cerebral Palsy and 3) Toileting.

Also attached is David's SIS Assessment dated January 9, 2020. Please note that David's medical needs via the SIS are now recognized to be a score of 13 when before it was a score of 5. This is a significant increase in noted supports.

For the above stated reasons, we would ask that you would re-consider David's level of care and see that the most appropriate daily level of care is Medium Medical.

Sincerely,

Jay C DeBoer
Guardian

Ann Braford
Co-Guardian

Name: DEBOER, DAVID LEONARD (63/M) Case #: 26338 Case Status: Open

Date of Birth
11/23/1956

Home Phone
(616) 284-4351

Address
David's House III
Wyoming, MI 49509

Guardian/Parent(s)
PREV JAY & LOIS DEBOER Phone: 6162435285

Current Admission
Primary Program: Community Living Services Supports Coordination
Case Holder: Elly Hamstra

Diagnosis
CDS

Authorization

CMH / Affiliate
Network 180

Provider
David's House Ministries NOVA David's House III (AM410289650)

Consumer
026338 DAVID L. DEBOER

Individual Plan of Service
IPOS Eff: 10/01/2019 Exp: 9/30/2020

Service Package

Authorization Number
1911A0065261

Date Authorized
11/13/2019

Authorization Status
Approved

Authorization Effective Date
10/01/2019

Authorization Expiration Date
09/30/2020

Authorizing Agent Notes
Requested Medium Medical, Approved Low Medical

David has two noted exceptional medical needs. The first is related to skin care integrity, where staff monitor for rashes and ensure that he engages in 30 minutes of pressure relief stretching three times per week. Staff support in this area is assessed to be a moderate intensity and frequency. The second exceptional medical need is related to his respiratory care. He is encouraged to wear his CPAP machine throughout the day, and he is assisted in tilting back in his chair twice per day for at least 5 minutes – working up to 15 minutes. This is also assessed to be a moderate intensity and frequency for staff support. Cumulatively, with two areas of exceptional medical need at a moderate intensity and frequency of staff support, David's needs are most appropriately met at a Low Medical daily level of care.

Provider Notes
T1020 Personal Care: Medium Medical 12 Beds - 45.04 per day
H2016 CLS: medium medical 12 beds - 78.68 per day

See external provider documents for SWA, guidelines, grid/ISB

Requested Date
11/13/2019

Requested / Added By
Brittany Fischers

Approved Date
11/19/2019

Supervisor Approved By

UM Approved By
Alyssa Stone

Services

Service
T1020: Personal Care, Per Diem

Unit Type
Days

Unit Rate
43.00

Effective Dates	Units per Period	Frequency	Total Units Requested	Total Units Authorized
10/01/2019 - 09/30/2020	1	Per Day	366	366