STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

Docket No. 2011-13299 CMH
Case No. 25442750

Appellant
_______________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on . appeared on behalf of the Appellant. She had no witnesses. , represented the Department. Her witness was .

PRELIMINARY MATTER

Appellant's proposed Exhibit #2, an undated letter from was received by fax post hearing and admitted without objection.

ISSUE

Did the CMH properly reduce the Appellant'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. The Appellant is Medicaid beneficiary receiving services through (CMH).

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. The Appellant is diagnosed with Pelizeaus-Merzbacher disease, severe mental retardation, underdeveloped immune system, asthma, and nystagmus. The Appellant is functionally nonverbal and non-ambulatory. (Exhibit A, sub D, page 15 of 24).

4. The Appellant lives with his and sees his two times a week.

(Exhibit A, sub D, throughout).

5. Appellant's [redacted] is his primary caregiver. (Exhibit A, sub D, throughout).

6. In Appellant's [redacted], PCP Outcome, ARC stated they would coordinate budget and pay staff for 30 hours/week of CLS. (Exhibit A, sub E, page 6 of 14).

7. On or about [redacted], the CMH performed a review of the Medicaid-covered services authorized for Appellant and reduced CLS to 15 hours a week. (Exhibit A, sub A, page 5).

8. During the review the CMH noted that some of the tasks for which Medicaid was paying for CLS were the responsibility of a parent to provide.

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying that the 30 CLS hours per week were not authorized, but that 15 hours of CLS was determined to be suitable for the Appellant's needs. (Department's Exhibit, Hearing Summary, page 1).

10. The Adequate Action Notice explained that 1206 units of CLS were authorized effective [redacted]. Further appeal rights were contained therein. (Exhibit A, sub A, page 5).

11. The State Office of Administrative Hearings and Rules (SOAHR) received the instant request for hearing on [redacted]. (Appellant's 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 she 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 Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. contracts with the Michigan Department of Community Health 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 Medicaid Provider Manual, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[1] it states, in relevant part:

> **CRITERIA FOR AUTHORIZING**
>
> 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

[1] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12 – 14, April 1, 2011

- 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) that 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.
(Emphasis supplied)

MPM, Mental Health [ ] §17.2 Criteria for Authorizing B3 Supports and Services, p. 104, April 1, 2011.[2]

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Furthermore, the Medicaid Provider Manual (MPM) directs the CMH and service users with the following criteria regarding CLS:

[2] This version of the MPM is identical to the edition in place at the time of notice and appeal.

Community Living Supports (CLS)

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, reminding, 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 appears to be needed, the beneficiary 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. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the 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 non-medical services

- Reminding, observing and/or monitoring of medication administration.

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

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings.

Transportation to medical appointments is covered by Medicaid through 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

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

MPM, *Supra* pp. 106-107

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At hearing the Department witness established that the Appellant's goals as recited in the PCP could be met with substantially fewer CLS hours than requested by the Appellant. The Department witness categorized the Appellant's request for 30 hours of CLS as inconsistent with prior decisions and failed to reflect a change in the Appellant's condition.

The Appellant's representative emphasized that the Appellant is "learning a lot on a daily basis" as he is home schooled. She said it is medically necessary to move his CLS back to 30 hours a week. However, the Department witness opined that the Appellant's mental health needs were sufficiently addressed with CLS at 15 hours per week.

[redacted] explained that during the development of the person centered plan the CMH will identify appropriate tasks and assign a reasonable time to them to develop the appropriate authorized CLS hours. [redacted] testified that upon review of the Appellant's prior plan it was noted that the Appellant was approved for CLS goals that were not realistic or age-appropriate for [redacted]. The CMH representative further observed that the Medicaid Provider Manual requires parents of children with disabilities to provide the same level of care they would provide to their children without disabilities.

[redacted] also said that difficulties with community-related tasks seemed typical of someone his age and were not related to his diagnosis. His specific issues with food preparation and management of household emergencies might also be largely age related limitations – not solely due to his identified disability. [redacted] added that the task of prompting for eating and toileting can be accomplished in 15 hours per week, and that Medicaid funding for 30 hours per week for these goals was not medically necessary.

The Appellant's [redacted] testified that the 30 CLS hours are necessary because the Appellant has no natural supports and that she is an "anxious [redacted]" who wants her [redacted] to get all of the supports he can get – because he is able to learn – albeit at a slower rate than non-disabled children. [*See* Appellant's Exhibit #2]

Today, the Department's CLS calculation is supported by medical necessity and is levied in the appropriate amount, scope and duration consistent with law and policy.

This Administrative Law Judge must follow the CFR and the state Medicaid policy, and is without authority to grant CLS hours out of accordance with the CFR and state policy. The [redacted] CMH provided sufficient evidence that it adhered to the CFR, state policy and the MPM when they authorized a reduction in CLS to 15 hours a week for the time period of [redacted], through [redacted].

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and to determine the amount or level of medically necessary services needed to achieve his goals. The PCP is not a static instrument and over time it will likely reflect changes in necessary supports for the Appellant - when those changes are manifest. At present the Appellant's proofs do not preponderate the required medical necessity for an increase in CLS.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's services to 15 CLS hours per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 4/15/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.