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

IN THE MATTER OF:

[redacted]

Docket No. 2012-59505 CMH
Case No. [redacted]

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 [redacted]. [redacted] the Appellant's mother/Guardian, appeared and testified on behalf of the Appellant. Appellant's grandmother [redacted] also testified on behalf of the Appellant.

[redacted] represented the Department's agent Kalamazoo County Community Mental Health and Substance Abuse Services (CMH). [redacted] LPC, LBSW, CAADC, Quality Improvement Manager, appeared and testified on behalf of the CMH. [redacted] LBSW, Customer Services Manager, was present but did not testify.

ISSUE

Did the CMH properly reduce Appellant's community living supports hours from 30 hours per week down to 20 hours per week?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant was a [redacted] female Medicaid beneficiary (DOB 8/17/2005) at the time of the hearing. (Exhibits C & G and testimony).

2. Kalamazoo County CMH is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. Appellant has been receiving Medicaid covered services through CMH, including supports coordination, family directed respite and 30 hours of community living supports (CLS) per week. (Exhibits A, C & G).

4. On [redacted], LPC, LBSW, CAADC, conducted a Utilization Management Review of Appellant's case to determine the current medical necessity for CLS hours. [redacted] stated that medical necessity was found for only 20 hours of community living supports per week. [redacted] found that the additional 10 hours of CLS that had been authorized were being used for services beyond the scope of CLS services, such as bathing, feeding, changing, and putting the Appellant to bed. [redacted] recommended that Appellant's CLS hours be reduced from 30 down to 20 hours per week. (Exhibits A, C & G and testimony).

5. On [redacted] Appellant's mother was sent an Advance Action notice that the CLS hours would be reduced to 20 hours per week effective [redacted] The letter informed Appellant of her rights to a fair hearing. (Exhibits A & G).

6. On [redacted] the Michigan Administrative Hearing System received Appellant's request for hearing. (Exhibit B).

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 Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH 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 amount, scope, and duration to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The Code of Federal Regulations, the state Mental Health Code, and Michigan Medicaid policy mandate that appropriate amount, scope and duration is to be determined through the person-centered planning process. It is indisputable that the federal regulations, state law, and policy, require the cooperation of both the Community Mental Health and the Medicaid beneficiary in the person-centered planning process.

The CMH must follow the Department's Medicaid Provider Manual when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply as follows:

> **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.
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> *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, July 1, 2012, pp. 12-14.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse Section* articulates Medicaid policy for Michigan, specifically including CLS.

> **17.3.B. COMMUNITY LIVING SUPPORTS**
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> 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 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 dura tion of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if neces sary, the benefic iary 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 bas ed 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 phy sician intervention)
  - socialization and relationship building
  - transportati on from the beneficiary's residence to community activities, am ong 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 even ts 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 pres erving the health and safety of the indiv idual 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 complem ent to, and in conjun ction with, state plan Personal Care services . Transportation to medical appointments is covered by M edicaid 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 ch ildren), or guardian of the

> beneficiary receiving community living supports. (Underline emphasis added by ALJ).
>
> 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 the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a 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.
>
> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensorymotor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child.
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> *MPM, Mental Health and Substance Abuse Section, July 1, 2012, Page 113.*

Initially CMH authorized the Appellant 30 CLS hours each week. However, the CMH's witness [redacted] stated that on [redacted] she conducted a Utilization Management Review of Appellant's case to determine the current medical necessity for CLS hours. (See Exhibit C). [redacted] stated that medical necessity was found for only 20 hours of community living supports per week. [redacted] found that the additional 10 hours of CLS that had been authorized were being used for services beyond the scope of CLS services, such as bathing, feeding, changing, and putting the Appellant to bed. [redacted] recommended that Appellant's CLS hours be reduced from 30 down to 20 hours per week.

Appellant's mother, [redacted] testified they have been receiving the 30 hours of CLS services for over two years and there has been a great improvement in their lives with this assistance. [redacted] stated she understood that there are certain criteria for funding Medicaid services, but she believed there were gray areas, and thinks continued funding for the additional CLS hours should be able to be approved.

[redacted] said she is a single parent, and the Appellant's father is not very involved with the Appellant. Also her mother helps as much as she can. [redacted] stated the Appellant's condition is not such that she is eligible for a nurse. Also DHS is not able to provide sufficient funding for child care services. [redacted] stated the CLS hours have increased the functionality of the family, allowing Appellant 's younger sister to get involved in more things since the CLS services were put in place. [redacted] stated she would agree to a reevaluation of their circumstances to see if their services could be increased.

[redacted] the Appellant's grandmother, indicated that [redacted] had melt downs before Appellant began receiving the CLS services. [redacted] does watch the Appellant for a short time on weekends, but the Appellant is now too heavy for her to lift. [redacted] stated she is not a trained caregiver and is not always able to deal with Appellant's medical issues. [redacted] stated the Appellant's father only watched her once in a month, which did not provide much relief for her daughter.

The testimony of the CMH's witness along with the documentary evidence admitted during the administrative hearing establishes that the CLS authorization of 20 hours per week is adequate to meet the Appellant's needs at this time. The Medicaid policy makes it clear that CLS hours cannot be used for personal care but rather must be utilized for skill development in the beneficiary. The items of personal care that the additional CLS services were being used for, such as bathing, feeding, changing, and putting the Appellant to bed, are beyond the scope of CLS services and cannot be supported with Medicaid dollars.

The CMH and the undersigned Administrative Law Judge are bound by the Code of Federal Regulations, the state Mental Health Code, and the Medicaid Provider Manual policy. While the CMH acknowledged that a reevaluation of the Appellant's case is always possible, based on the credible, preponderant evidence in this record, it was proper for the CMH to reduce Appellant's CLS hours to 20 hours per week.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the reduction of the Appellant's community living supports hours from 30 hours per week down to 20 hours per week was proper.

IT IS THEREFORE ORDERED that:

The CMH decision to reduc e Appellant's community living supports hours from 30 hours per week down to 20 hours per week is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/30/2012

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.