STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-7053 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Case Manager, [redacted], represented the Appellant. [redacted], the Appellant, appeared and testified. [redacted], Fair Hearings Officer, appeared on behalf of [redacted] County Community Mental Health (CMH or Department). [redacted], Quality Management Supervisor, appeared as a witness for the Department. [redacted] appeared as an interpreter.

ISSUE

Did the CMH properly deny the Appellant's request for 35 hours per week of Community Living Supports (CLS) and, instead, only authorize 7.5 hours per week of CLS services?

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 a [redacted]-year-old [redacted] who has been diagnosed with schizoaffective disorder, post-traumatic stress disorder, psychotic disorder and borderline personality disorder. The Appellant is deaf and uses American Sign Language for communication purposes. (Exhibit 1, pages 43 and 50)

2. The Appellant currently lives in an apartment in [redacted] Michigan. (Exhibit 1, page 48)

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

4. The CMH in turn contracts with various service providers, including Deaf Services.

5. The Appellant is currently receiving targeted case management, CLS, and medication review services. (Fair Hearings Officer Testimony)

6. On [redacted], an Individual Plan of Service Meeting (IPS) was held. A request was made for the authorization of CLS in the amount of 35 hours per week. (Exhibit 1, page 4 and Fair Hearings Officer Testimony)

7. Many of the goals and objectives in the IPS did not pertain to CLS. (Exhibit 1, pages 7-15; Quality Management Supervisor Testimony)

8. On [redacted], CMH sent the Appellant a Notice and Hearing Rights stating that 7.5 hours of CLS per week has been approved of the 35 hours requested because medical necessity for additional hours was not met. This notice also contained the Appellant's rights to a Medicaid fair hearing. (Exhibit 1, pages 1-3)

9. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on the Appellant's behalf. The hearing request was resubmitted on [redacted] with the Appellant's signature. (Exhibit 2)

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.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to Community Living Supports (CLS):

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> 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 duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary 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 based 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 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 nonmedical 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 Personal Care services. 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.

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2012, Pages 113-114
(Underline added by ALJ).

While CLS is a Medicaid covered service, Medicaid beneficiaries are also only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230.

With respect to medical necessity, the Medicaid Provider Manual states:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

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.

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2012, Pages 12-13.

Moreover, in addition to requiring medical necessity, the Medicaid Provider Manual also states that B3 supports and services, such as Community Living Supports, are not intended to meet every minute of need:

> 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) who 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.

Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2012, Page 111
(Underline added by ALJ)

The Quality Management Supervisor testified that she has a masters of science degree and is a limited license psychologist. Until recently she was a Utilization Management Coordinator and in that role, she reviewed the action at issue in this case, the Appellant's request for 35 hours of CLS. A Utilization Management Coordinator reviews the IPS and any other assessment documents for medical necessity and

appropriateness of services. The Quality Management Supervisor went over the goals and objectives in this IPS in some detail including areas that allowed for authorization of CLS hours and explaining that many of the goals and objectives did not pertain to CLS so hours were not authorized for these areas. Further, CLS covers guidance and teaching with an activity, but cannot supplant state plan services, such as assistance with Activities of daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that would be covered under the Department of Human Services Home Help Services program. For example, meal preparation is an IADL included in the Home Help Services program. Therefore, some CLS hours were authorized for menu planning, but not for the actual meal preparation itself. (Quality Management Supervisor Testimony)

The Appellant disagrees with the amount of CLS hours authorized. The Case Manager noted this was a drastic cut as the Appellant used to get 35 hours per week of CLS. The Appellant has not been doing well lately and there have been a lot of issues with her behavior. There is not enough staff with the fewer hours of CLS. The Appellant has gone to the emergency room a lot lately, and has been calling the crisis line and customer service multiple times per day. A recent request for more hours was made, but was still denied. The Case Manager was informed that another appeal could be filed regarding this denial. (Case Manager Testimony)

The Fair Hearings Officer explained that previously, the Appellant was receiving services through a COFR arrangement with a different county CMH. Accordingly, that county CMH was the authorizer of services. Since then, this CMH has taken over the Medicaid funding and the authorization now goes through this CMH. The Fair Hearings Officer noted that the action in dispute for this appeal was the limited denial of the request for 35 hours per week of CLS based on the current plan of service. (Fair Hearings Officer Testimony)

The Appellant testified she needs more hours to work on all the goals she typed up with her case manager and more time for enjoyment. The Appellant is upset and does not understand the reason more hours for staff was denied. The Appellant wants more hours to work on all of these things so she can grow and become better and happier. The staff helps the Appellant and teaches her. The staff is not mean to the Appellant but they do let her know when she makes a mistake. (Appellant Testimony)

While this ALJ understands that the Appellant previously received more hours authorized through a different county CMH, and there has been a more recent denial regarding her CLS, this hearing is limited to reviewing only the [redacted] action. The Appellant bears the burden of proving by a preponderance of the evidence that the 7.5 hours per week of CLS hours authorized would be inadequate to reasonably achieve the Appellant's goals for the plan of service at issue. Based on the evidence presented, Appellant has failed to meet that burden. Many of the goals listed in the [redacted] plan of service did not relate to CLS. The authorized 7.5 hours should be adequate for CLS related goals in the [redacted] plan of service. Based on the information available at that time, the CMH's determination is upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant's request for 35 hours per week of CLS and, instead, authorized only 7.5 hours per week of CLS services.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: April 5, 2013

***** 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.