

**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) 373-4147

IN THE MATTER OF:

████████████████████
Appellant
_____ /

Docket No. 2013-9040 CMH
Case No. ██████████

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 ██████████. ██████████, Advocate, The ██████████, appeared and testified on behalf of the Appellant. ██████████, Appellant's ██████████ and ██████████ also testified on behalf of the Appellant. Appellant ██████████ was present but did not testify.

St. Clair County Community Mental Health Authority (CMH) was represented by ██████████, Fair Hearings Officer, who appeared on behalf of the CMH. ██████████, LBSW, Supports Coordinator, and ██████████, Ph.D., a Licensed Psychologist, Director of Thumb Alliance PIHP, appeared and testified on behalf of the CMH.

ISSUE

Did the CMH act properly when it determined to deny Appellant's request for additional community living supports?

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 ██████ year-old female Medicaid beneficiary (DOB: ██████████) at the time of the hearing. (Exhibits 2, 9 and Testimony).
2. St. Clair County Community Mental Health Authority (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

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3. Appellant is an adult with a developmental disability, she is legally blind, she has diagnoses of moderate mental retardation, cerebral palsy, and adjustment disorder with depressed mood. (Exhibits 3, 9, B and Testimony).
4. On [REDACTED], following an additional case review and a local appeal brought by Appellant's [REDACTED] an Individual Plan of Service was completed for the Appellant which authorized 13 hours per week of Community Living Supports (CLS). (Exhibits 1, 9 and Testimony).
5. On [REDACTED] Adequate Action Notice was sent to the Appellant's [REDACTED] advising that the Appellant could ask for a Medicaid Fair Hearing if they did not agree with the services authorized in the new IPOS. (Exhibit 10).
6. On [REDACTED], the Michigan Administrative Hearing System received Appellant's request for hearing, signed by her [REDACTED], seeking seven additional CLS hours per week to assist Appellant in attending her chemotherapy and radiation appointments for her breast cancer treatment. (Exhibit A).

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

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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, October 1, 2012, 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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance
- abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- 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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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. [pp. 12-14].

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The *Medicaid Provider Manual, Mental Health/Substance Abuse, October 1, 2012*, Section 17, articulates Medicaid policy for Michigan, for B3 services including Community Living Supports (CLS).

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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
- 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) 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. [p. 111].

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

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- 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. (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

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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. [p. 114].

The testimony of CMH's witness along with the documentary evidence admitted during the administrative hearing shows that the Appellant and her ██████████ had requested that Appellant receive an additional seven CLS hours per week to assist Appellant in attending her chemotherapy and radiation appointments for her breast cancer treatment. On ██████████, when the meeting was held to prepare a new IPOS for the Appellant, 13 hours per week of CLS services were authorized for the Appellant. Appellant appealed the denial of the additional 7 hours of CLS requested.

Appellant's Supports Coordinator, a Licensed Bachelor Social Worker, stated she has worked with the Appellant for almost eight years. She stated it is her job to coordinate supports for the Appellant in conjunction with the Appellant's yearly plan of service. The Supports Coordinator stated that Appellant's CLS hours were increased to 20 hours per week when she moved into a ██████████ apartment in ██████████. However, when Appellant was diagnosed with cancer, she was moved back to her ██████████ with her ██████████. At that point her CLS hours were reduced to four hours per week. Thereafter, the family asked for 20 CLS hours, but only 13 CLS hours per week were authorized at the administrative level. It was determined that the additional 7 CLS hours for chemotherapy treatments would not be covered by their contract CLS, but the Department would be able to provide those services.

The Supports coordinator stated that she contacted ██████████ office and they stated they would provide support for the Appellant at the chemotherapy appointments, and would provide staff to assist her to the bathroom, or any support that she might need while she was at her appointments. She also obtained a letter from ██████████ office that states when the Appellant "is in the office for chemotherapy the Registered Nurses we have on staff are able to help her to the restroom along with other things she might need such as a drink. They also monitor her infusions and her drugs." (See Exhibit 11). The supports coordinator stated that natural supports (the Registered Nurses) were providing the needed supports for the Appellant while she was attending her chemotherapy appointments at no cost to the Department.

The Supports Coordinator has advised the Appellants ██████████ that they would assist with transportation if needed and with assistance if needed at future doctor's appointments. She further stated that additional supports have not been authorized yet, and will not be authorized until the specific need arises. The Supports Coordinator stated the Appellant's ██████████ has requested that the contract CLS worker be paid to provide the needed support, but the Department has not authorized that this particular individual provide the requested support, because they were going to authorize it within their own agency. The Director of Thumb Alliance PIHP, a Licensed Psychologist, concurred in the testimony of the Supports Coordinator.

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The Appellant's Advocate testified that the Appellant has a panic disorder concerning her diagnosis and treatment, and wants the contract CLS worker to provide the CLS hours needed to assist at her medical appointments. The Advocate advised that the [REDACTED] would provide needed transportation, and she stated the hospital where Appellant would be receiving her future radiation treatments wants a caregiver present during the treatments.

The Appellant's [REDACTED] testified at the hearing that the Appellant will be having her surgery [REDACTED] of [REDACTED]. She acknowledged that the [REDACTED] will provide the Appellant transportation. The [REDACTED] further testified that she contacted the hospital where the radiation treatments will be, and they indicated the Appellant needs a caregiver present for the treatments. The Appellant's [REDACTED] stated that after her [REDACTED] the Appellant will be scheduled for six weeks of [REDACTED] treatments, seven days per week. They are requesting that the Appellant get the supports she needs at upcoming medical appointments.

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. In this case, Appellant was denied CLS services due to the fact that the assessment for CLS showed that her needs at that time would be met through natural supports, i.e., the registered nurses at the doctor's office where the chemotherapy treatments were given. In short, medical necessity was not shown for the authorization of the additional CLS services. The preponderance of the evidence shows that the services authorized in Appellant's new IPOS were sufficient to meet the Appellant's needs at that time.

At the hearing, the Appellant's witnesses focused on the need for future supports following the Appellant's surgery that is to take place next week. The Department has indicated that it will provide the necessary supports as the need arises, but that it would not authorize the specified contract CLS worker to perform those support services, because they were going to authorize the services within their own agency. According to the above policy contained in the Medicaid Provider manual, the PIHP may deny requested services 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.

In conclusion, Appellant has failed to show by a preponderance of the evidence that CMH's denial of the additional seven CLS hours was improper. CMH's decision to deny the additional CLS services in the Appellant's new IPOS should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH's denial of additional CLS services was proper.

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IT IS THEREFORE ORDERED that:

The CMH decision to deny Appellant additional CLS services is **AFFIRMED**.

/s/

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: February 27, 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.