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:

[redacted]

Docket No. 2013-35634 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 request for a hearing filed on behalf of Appellant/Petitioner.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's mother/guardian, appeared and testified on Appellant's behalf. [redacted], the transition coordinator at [redacted] in [redacted], Michigan, and [redacted], an advocate from The [redacted] County, also testified on Appellant's behalf. [redacted] and [redacted], hearing officers, represented the [redacted] County Community Mental Health Authority (CMH). Attorney [redacted] appeared on behalf of [redacted], Inc. [redacted], Family Services Director, and [redacted], supports coordinator, from [redacted], Inc. also testified as witnesses.

ISSUE

Did the CMH properly deny Appellant's request for 38 hours of Community Living Supports (CLS) per week and, instead, only authorize 15 hours a week of such 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. Appellant is a [redacted] year-old woman who has been diagnosed with a cognitive impairment. (Respondent's Exhibit A, page 12).

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

3. In turn, the CMH contracts with service providers such as Community Living Services, Inc. to provide Medicaid covered services.

4. Appellant has been receiving 10 hours of respite care services per month through the CMH and Community Living Services, Inc. (Testimony of Appellant's representative; Testimony of [redacted]).

5. Appellant also receives 10 hours a week of Adult Home Help Services (HHS) through another Medicaid program. (Respondent's Exhibit A, page 9; Testimony of Appellant's representative; Testimony of [redacted]).

6. Appellant's mother is her HHS care provider and receives $[redacted] per month for providing HHS. (Respondent's Exhibit A, page 9).

7. In a letter dated [redacted], Appellant requested Community Living Supports (CLS) from the CMH and [redacted], Inc. (Respondent's Exhibit A, page 6; Testimony of Appellant's representative; Testimony of [redacted]).

8. On [redacted], the parties held a person-centered planning meeting. Appellant, Appellant's guardian, Appellant's teacher, [redacted], [redacted], and [redacted] were present for that meeting. (Respondent's Exhibit A, pages 10-11).

9. While no decision was made during the meeting with respect to the request for CLS, Appellant's guardian received an Adequate Notice of Action for Medicaid Fair Hearing and Local Appeal Rights. (Respondent's Exhibit A, pages 2-3).

10. That notice stated that it was being provided following an Individual Plan of Service (IPOS) development, amendment or periodic review. (Respondent's Exhibit A, pages 2-3).

11. It also provided that Appellant had 90 days from the date of the notice to file an appeal. (Respondent's Exhibit A, pages 2-3).[1]

12. Soon after that meeting, Appellant's representative submitted a document detailing Appellant's daily routine at [redacted] request. (Respondent's Exhibit A, pages 4-5).

13. At some point, possibly during a follow-up meeting on [redacted], [redacted] or [redacted] informed Appellant's representative that only 15 hours a

[1] Respondent erred by only providing a written notice of Appellant's right to appeal prior to the decision being made. It should have provided written notice of the actual denial and that Appellant has 90 days from the date of that notice to request a hearing. Nevertheless, given subsequent events, the error was immaterial in this case.

week of CLS would be approved. (Respondent's Exhibit A, pages 8-9; Testimony of Appellant's representative; Testimony of [redacted]).

14. On [redacted], Appellant's representative signed a Person-Centered Planning Feedback Sheet and checked that she disagreed with the Personal Plan. (Petitioner's Exhibit 1, page 3).

15. On [redacted], the Michigan Administrative Hearing System (MAHS) received a Request for Hearing with respect to the partial denial of CLS in this case. (Petitioner's Exhibit 1, pages 1-4).

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.]
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> * * *
>
> 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.]

Moreover, 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. CMHSP contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Among the services that can be provided by the CMH are Community Living Supports (CLS). With respect to CLS, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **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 (that exceeds state plan for adults), prompting, reminding, cueing, 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 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. [MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, pages 110-114.]

However, while CLS are Medicaid-covered services, Medicaid beneficiaries are only entitled to medically necessary covered services for which they are eligible and 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. With respect to medical necessity, the MPM, January 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 12-13, provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
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> **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.

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
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> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
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> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.
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> *****
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> **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.
>
> 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. [MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, pages 110-111.]

Here, it is undisputed that Appellant needs some CLS and it is only the amount of hours to be authorized that is at issue. As discussed above, while the CMH and service provider are willing to authorize 15 hours a week of CLS, Appellant's representative is requesting 38 hours a week of such services.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH/service provider erred in denying her request for additional CLS hours. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

As documented in the proposed daily routine provided by Appellant's representative, she is seeking additional CLS in part as an attempt to account for every hour and minute of Appellant's time. Appellant's representative testified that Appellant cannot be left alone for safety reasons and any idle time is detrimental for her development.

However, CLS is not meant to address safety concerns or gaps in care. Instead, CLS are only to be used "to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 113). Similarly, B3 supports and services in general are intended to "to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 110).

Additionally, while the alleged effects of idle time should be a factor in allocating CLS, decisions regarding the authorization of a B3 service such as CLS, including the amount of services, "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 111). That is especially true in this case given Appellant's other services and activities. Appellant was authorized a significant amount of CLS, *i.e.* 15 hours. Moreover, she also attends school 5 days a week and receives 10 hours a week of Adult Home Help Services. 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." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 111).

Regarding Appellant's other supports, Appellant's mother/representative testified that she has been taking care of Appellant for 19 years and that she now needs help. However, as described above, providing general care or relieving a caregiver's stress is not the goal or function of CLS. Respite care services, on the other hand, "are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 124). Appellant's representative is already receiving 10 hours a month of respite in this case and indicated during the hearing that she intends to ask for more. She is free to do so in the future, but this Administrative Law Judge's jurisdiction is limited to the request for CLS and partial denial that are at issue here and any potential need for additional respite does not justify additional CLS.

Given the non-covered reasons for which Appellant's representative seeks additional CLS, in addition to the significant services Appellant already receives, this Administrative Law Judge finds that Appellant has failed to meet her burden of proof with respect to the denial of additional CLS. Accordingly, the decision to only authorize 15 hours a week of CLS is affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH/Community Living Services, Inc. properly denied Appellant's request for 38 hours of CLS per week and, instead, only authorized 15 hours a week of such services.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

Date Signed: 6/17/2013

[redacted]

Docket No. 2013-35634 CMH
Decision and Order

Date Mailed: 6/17/2013

cc: [redacted]

***** 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.