

**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:

Docket No. 2013-51430 CMH

██████████,

██████████

██████████

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 ██████████ ██████████ father, represented the Appellant. ██████████, Corporate Counsel, represented ██████████ County Community Mental Health and Substance Abuse Services ("CMH" or "Department"). ██████████, Quality Improvement Manger, appeared as a witness for the CMH. ██████████, Customer Service Representative, was also present.

ISSUE

Did the CMH properly reduce the Appellant's Community Living Supports ("CLS") and Respite authorizations?

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 ██████-year-old male who has been diagnosed with autistic disorder by history, mood disorder NOS, history of diabetes mellitus, juvenile rheumatoid arthritis, cardiac issues, past history of renal failure and mild cerebral palsy. (Exhibit 1, pages 4 and 9)
2. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the applicable service area.
3. The CMH in turn contracts with various service providers, including Community Mental Health and Substance Abuse Services of ██████████ County ("CMHSASSJC").

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4. The Appellant's father has full legal and physical custody of the Appellant. The Appellant has ongoing supervised visitation with his mother. (Exhibit 1, page 6; Quality Improvement Manger Testimony)
5. The Appellant previously received [REDACTED] hours per week of Respite services and [REDACTED] hours per week of CLS services through CMHSASSJC. (Attachment to Hearing Summary)
6. In [REDACTED], the Appellant's prior request for an administrative hearing was withdrawn because there was no documented reduction in services. At that time, a review of services was completed and a reduction in Respite and CLS hours was recommended. (Attachment to Hearing Summary; Exhibit 1, page 13)
7. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the hearing request filed on behalf of the Appellant. (Exhibit 1, page 3)
8. On [REDACTED], an updated Utilization Management Review was completed. It was noted that the Appellant has made steady progress on his goals, as previously delivered there was little difference between the CLS and Respite services, the new Plan of Service has more focused CLS goals with reduced CLS hours, and the Respite hours would be reduced once the Appellant returns to school. It was further noted that there had been some difficulty in providing the approved level of service due to a change in providers, but a plan was implemented to address this issue. The recommendation to reduce the Appellant's Respite and CLS hours was found to be appropriate under the medical necessity criteria found in the Medicaid provider manual. (Attachment to Hearing Summary; Exhibit 1, pages 4-13; Quality Improvement Manger Testimony)

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

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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 also 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... [42 USC 1396n(b).]

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.

While Respite and CLS are Medicaid covered services, Medicaid beneficiaries are 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;
- 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.

*Medicaid Provider Manual
Mental Health and Substance Abuse Section,
January 1, 2013, Pages 12-13*

The Medicaid Provider Manual also explicitly states that B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

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,
January 1, 2013, Page 111*

Regarding CLS, the Medicaid Provider Manual states:

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:

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- 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 services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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

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- 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.

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, sensory-motor, 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. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

*Medicaid Provider Manual
Mental Health and Substance Abuse Section,
January 1, 2013, Pages 113-115*

Regarding Respite, the Medicaid Provider Manual states:

17.3.J. RESPITE CARE SERVICES

Respite care services 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. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

*Medicaid Provider Manual
Mental Health and Substance Abuse Section,
January 1, 2013, Page 124*

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The Quality Improvement Manger conducted the [REDACTED] Utilization Management Review and the update in [REDACTED]. In part, the information considered included incident reports and progress reviews. There had been a clear decrease in the frequency of incident reports since [REDACTED]. The review noted that the Appellant has made steady progress on his goals, as previously delivered there was little difference between the CLS and Respite services, the new Plan of Service has more focused CLS goals with reduced CLS hours, and the Respite hours would be reduced once the Appellant returns to school. It was further noted that there had been some difficulty in providing the approved level of service due to a change in providers, but a plan was implemented to address this issue. The recommendation to reduce the Appellant's Respite and CLS hours was found to be appropriate under the medical necessity criteria found in the Medicaid provider manual. (Attachment to Hearing Summary; Exhibit 1, pages 4-13; Quality Improvement Manger Testimony)

The Appellant's father disagrees with the reduction to the Appellant's Respite and CLS hours and asserted the CMH did not receive all the appropriate information from the Appellant's case manager. The Appellant's father described the communication problems he has experienced with the case manager. This included not developing an appropriate treatment plan for the Appellant previously. The Appellant's father provided dates of police reports for fourteen incidents since [REDACTED] but also indicated that not all incidents have resulted in police reports. There is concern that information has not been considered from the school despite releases for the CMH and Intermediate School District to share information. The Appellant's father also questioned if the letter from the Appellant's doctor stating it was necessary to continue services was received by the CMH. (Father Testimony; Exhibit A) The Quality Improvement Manger testified this letter was not received. (Quality Improvement Manger Testimony)

The Appellant's father described examples of incidents, such as school staff having difficulty keeping the Appellant from running during filed trips, the police being called a week prior to the [REDACTED] hearing proceedings because the Appellant was assaultive and throwing things at his father, and the Appellant kicking a woman in the back on the bleachers on [REDACTED]. The Appellant's father also provided credible testimony of the Appellant's destructive capability and the damage to the home from some of the Appellant's incidents. The Appellant's father asserts that just because the intensity and frequency has improved does not mean that things are good with the Appellant. (Father Testimony)

The Appellant has the burden of demonstrating by a preponderance of the evidence that Respondent erred in reducing the Appellant's Respite and CLS authorizations. In this case, the Appellant has failed to meet that burden of proof. It is clear that the Appellant's father is concerned with the Appellant's behavior(s), and that there were concerns with the prior case manager. (Father Testimony) It also appears that the difficulty in providing the approved level of services due the change in providers significantly contributed to the more recent increase in incidents with the Appellant. Until this difficulty, there was reported improvement with the Appellant. The Appellant's father's testimony even acknowledged improvement in intensity and frequency. Further,

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cc:



***** 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.