

**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. 2013-60034 CMH

██████████

**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 ██████████ Appellant's mother and power of attorney appeared on behalf of the Appellant. ██████████ appeared as an authorized representative of ██████████ and spoke on Appellant's behalf. ██████████ Fair Hearings Officer, represented the ██████████ County Community Mental Health (CMH). ██████████, Case Manager, appeared and testified on behalf of the CMH.

**ISSUE**

Did the CMH properly determine that Appellant's services for Community Living Supports and Mileage must be reduced?

**FINDINGS OF FACT**

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

1. At the time of the hearing, Appellant was ██████-year-old male Medicaid beneficiary with severe mental retardation, cerebral palsy, and microcephaly, and significant sensory issues. ( Department Exhibit A)
2. ██████████ County Community Mental Health (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. At all times relevant to this matter, Appellant has been receiving Medicaid covered services through the CMH as a person with a developmental disability, including community living supports (CLS), respite care, and mileage reimbursement.
4. In late summer and early fall of ██████, several other CMH boards in the ██████ County CMH region shared the documents they were using to determine the CMH services being provided to consumers.
5. Based upon the review of the documents shared by other CMH boards, ██████ County CMH determined that they were authorizing services far in excess of the services being authorized by the other CMH boards, and therefore, they decided to place themselves: "in the middle of the range for those services where we authorizing in excess of other boards. Based upon the new ranges it was determined that as plans came up for annual review the plans would be revised in keeping with new authorization grid. There was also the understanding that in some cases families may need time to make the changes and accommodations." (Department Exhibit A, p. 3)
6. As the number of individuals being served by ██████ CMH increased from ██████ to ██████ per year, the CMH determined that: "it became imperative to find fair and equitable methods to manage the benefits and allow us to meet the increasing demand for services"; therefore, the CMH implemented a new level of care tool to determine the amount, scope, and duration of the CMH services an individual may be eligible to receive. (Department Exhibit A)
7. On ██████, a new CMH Treatment Plan was created for Appellant for the period of ██████ to ██████ (Department Exhibit B)
8. After implementation of their new level of care system, the CMH completed an annual assessment of Appellant's CMH eligibility and determined that his new Person Centered Treatment Plan effective ██████ was to reduce Appellant's CLS to ██████ units per year and reduce mileage reimbursement to ██████ per year. (Department Exhibit B)
9. At all times relevant to this matter, Appellant was approved for ██████ annually for Respite Care Services. (Department Exhibit B)
10. Appellant's Inventory for Client & Agency Planning (ICAP) scores for the past ██████ years are as follows: ██████ in ██████; ██████ in ██████; and ██████ in ██████; and the decrease in scores shows increasing need for services. (Department Exhibit A, p 1)

11. Appellant's mother/legal guardian refused to sign the new Treatment Plan because she disagreed with the CMH's decision to reduce the amount of services being provided to Appellant.
12. The action to reduce Appellant's CMH services was deleted pending hearing. (Department Exhibit B, p. 6)
13. On ██████████, the Michigan Administrative Hearing System received Appellant's Request for Hearing, protesting the proposed reduction in services.

### **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, 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, emphasis added].

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, emphasis added].

### **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

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- 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. (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. [p. 114].

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### **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

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care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid. [p. 124].

Appellant is a █████-year-old Medicaid beneficiary with a developmental disability. He was diagnosed with severe mental retardation, cerebral palsy, and microcephaly, and significant sensory issues. At all times relevant to this matter, Appellant has been receiving B3 services, CLS, Respite, and a reimbursement for mileage.

Based upon a review of the documents shared by other CMH boards, ██████████ County CMH determined that they were authorizing services far in excess of the services being authorized by the other CMH boards. As the number of individuals being served by ██████████ CMH increased from █████ to █████ per year, the CMH determined that it was imperative for them to find fair and equitable methods to manage benefits and allow them to meet the increasing demand for CMH services. In █████, the CMH implemented a new level of care system to determine the amount, scope and duration of CMH services provided to eligible beneficiaries. The CMH completed its reassessment of Appellant's eligibility for CMH services and determined that his new Person Centered Treatment Plan, effective ██████████ to ██████████ would be a reduction of CMH services. Appellant's CLS services were reduced to █████ units annually, and he was given an annual mileage reimbursement of █████. The CMH representative provided documentation to establish that the CMH is not proposing to reduce the level of Respite

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Care services that Appellant has been receiving, and Appellant did not dispute the CMH's evidence regarding these services. Based on testimony, Appellant's representative had an issue with the way the proposed Respite treatment plan was written.

Appellant's mother refused to sign the Person Centered Treatment Plan and is requesting that Appellant receive an additional ██████████ hours of CLS per week. ██████████ who was authorized to speak on ██████████ and Appellant's behalf, testified that the amount given for mileage reimbursement is also inadequate to meet Appellant's needs.

The preponderance of evidence on the record supports the Appellant's assertion that a reduction in his CMH services is not warranted. ██████████ County CMH provided documentation to establish that Appellant's ICAP scores in the past ██████████ years have decreased, and "the decrease in scores shows an increasing need for services." The CMH stated further that: "The level of care document ...shows the relation between needs identified in the ICAP and amount of services to be authorized and Steven is at level 4....Should ██████████ score continue to decrease he will reach level 5...which is the highest level of care." (Department Exhibit A, p 1)

██████████ County CMH failed to meet its burden of going forward and establishing that it properly reduced the CMH services that Appellant had been authorized to receive. The CMH failed to establish that the services authorized in Appellant's proposed person-centered plan for the year ██████████ are appropriate in amount, scope and duration to achieve the goals of community participation and integration and meet Appellant's medically necessary needs. After reviewing several other CMH boards willing to share the documents they used to determine amount, scope and duration of services, ██████████ County CMH decided to place themselves in the middle of the range for those services where they were authorizing in excess of other boards. Based on the evidence on the record, the decision to reduce Appellant's services was based solely on the CMH's limited budget and the need to serve more consumers. The CMH representative, ██████████, testified that ██████████ County CMH has a desire to serve as many consumers as it can, and they are not able to serve everyone. ██████████ testified that ██████████ County CMH is doing the best that they can with their limited budget for Medicaid covered services. Medicaid policy does allow the CMH to: "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." (MPM, Section 2.5.D) However, the CMH's limited budget cannot be used as the basis to reduce the CMH services that a Medicaid beneficiary is entitled to receive under the applicable law and Medicaid policy. The applicable law and Medicaid policy prohibits the denial or reduction of services based **solely** on preset limits of the cost of CMH services and requires that the medical necessity criteria be applied in determining the appropriate mental health, developmental disability or substance abuse services needed to assist the Medicaid beneficiary to attain or maintain a sufficient level of functioning in order to achieve goals of community inclusion and participation, independence, recovery, or productivity. B3 services and supports are not intended to meet all of the beneficiaries

needs. Additionally, some needs may be better met by community and other natural supports who are willing and able to provide assistance. The Medicaid policy, Mental Health Code, and the Code of Regulations clearly state that Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Those services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered services. (see 42 CFR 440.230) Additionally, the CMH is required to use a person-centered planning process to identify medically necessary services. The person-centered planning process is designed to provide beneficiaries with a “person-centered” assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant’s person-centered plan or IPOS.

In conclusion, the preponderance of evidence fails to establish that the CMH properly reduced Appellant’s CMH services in accordance with the applicable law and policy. The evidence on the record establishes clearly that Appellant’s need for CMH services has increased in the past ████████ years. The CMH provided no evidence to establish that the services that had been previously authorized for Appellant were in excess of what was medically necessary for Appellant to receive. Therefore, the CMH eligibility determination cannot be upheld.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH failed to establish that it properly reduced Appellant’s CMH services.

**IT IS THEREFORE ORDERED** that:

The CMH decision to reduce the Appellant’s Medicaid covered services is REVERSED.

It is further ordered that the CMH must initiate a reassessment of Appellant’s eligibility for CMH services in accordance with the applicable law and policy.

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Marya A. Nelson-Davis  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

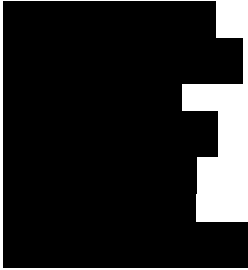
Date Signed: ██████████

Date Mailed: ██████████

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MAND/db

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.