

**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) 334-4147

IN THE MATTER OF:

██████████

Appellant

_____ /

Docket No. 2013-67336 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 ██████████. ██████████, Appellant's mother, appeared and testified on Appellant's behalf. Appellant's witness was ██████████, Supports Coordinator.

██████████, Assistant Corporation Counsel, ██████████ County Community Mental Health Authority (CMH), represented the Department. ██████████, ██████████ Supervisor, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request for 100 additional Community Living Supports (CLS) hours per month?

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 █ year old Medicaid beneficiary, born ██████████, receiving services through ██████████ County Community Mental Health (CMH). (Exhibit C, p 12; Testimony)
1. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.
2. Appellant is diagnosed with GERD, bronchomalacia, cerebellar ataxia, encephalopathy unspecified and mental retardation unspecified.

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Appellant has substantial limitations in self-care, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, and expressive/receptive language. (Exhibit C, p 28; Testimony)

3. Appellant lives with his parents and sibling in a single family home. (Exhibit C, p 28; Testimony)
4. Appellant receives in-home schooling from ██████████ because he is at high risk for infection if he goes to school. (Exhibit C, p 28; Testimony)
5. Appellant currently receives 2400 units (100 hours per month) of CLS and his parents receive 1200 units (50 hours per month) of respite through CMH. (Exhibit B, p 10; Testimony) Appellant has also been receiving Occupational Therapy (OT) and Physical Therapy (PT) at ██████████ ██████████, paid for through Medicaid Children's Special Healthcare, not CMH. PT was recently stopped because Appellant could not get to the appointments. (Testimony)
6. In ██████████, Appellant's supports coordinator requested an additional 2400 units of CLS per month on Appellant's behalf. The request was reviewed and denied as the CMH determined that a review of the clinical information found that the additional CLS hours were excessive and that the current authorized amount of CLS hours was sufficient to meet Appellant's needs as identified in his Person Centered Plan (PCP). (Exhibit B, p 9; Exhibit G; Testimony)
7. On ██████████, CMH sent Appellant's mother an Adequate Action Notice informing her that the request for additional CLS hours had been denied. (Exhibit A, p 6)
8. Appellant's request for a hearing was received by the Michigan Administrative Hearing System on ██████████. (Exhibit 1)

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 scope, duration, and intensity to reasonably achieve the purpose of the covered service. See *42 CFR 440.230*.

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The *Medicaid Provider Manual, Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan. It states, in relevant part:

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.

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, (revised 7/1/2011), observing, guiding and/or training in the following activities:
 - meal preparation
 - laundry
 - routine, seasonal, and heavy household care and maintenance
 - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
 - shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed

home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:
 - money management
 - non-medical care (not requiring nurse or physician intervention)
 - socialization and relationship building
 - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
 - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
 - attendance at medical appointments
 - acquiring or procuring goods, other than those listed under shopping, and nonmedical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

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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.

July 1, 2013, pp 112, 114-115.

The CMH witness testified that Appellant's request for an additional 100 hours of CLS hours per month was denied because the CMH determined, upon a review of the clinical information, that the additional CLS hours were excessive and that the current authorized amount of CLS hours was sufficient to meet Appellant's needs as identified in his Person Centered Plan (PCP). The CMH witness testified that Appellant is currently receiving 5 hours per day of services, which should be sufficient to meet his goals of supervision and assistance with his home exercise program. The CMH witness also indicated that, at the time the decision to deny additional CLS hours was made, she did not have any medical documentation from Appellant's parents indicating that they had physical restrictions or limitations of their own.

Appellant's supports coordinator testified that her request for additional CLS hours for supervision may have been too general, but she filled out the request the best way she knew how. Appellant's supports coordinator indicated that Appellant continues to grow, cannot sit for very long, and is often left on his back with a feeding tube. Appellant's supports coordinator indicated that Appellant is no longer receiving PT at ██████████ and only receives OT there once per month. Appellant's supports coordinator indicated that CLS staff has to spend much of their time lifting and moving Appellant, which cuts into the time they can perform skill development activities with Appellant, because Appellant's family cannot move Appellant because of their own physical limitations. Appellant's supports coordinator also indicated that Appellant's tolerance level for activities varies greatly throughout the day, so it is difficult to schedule CLS workers.

Appellant's mother indicated in the request for hearing that she relies on Appellant's workers to transfer Appellant in and out of his playpen, wheelchair, bed and in and out of the home on a daily basis. Appellant's mother indicated that Appellant's community inclusion is severely limited due to staff availability with the current allocation of hours. Appellant's mother testified that Appellant has more conditions and diagnoses than those listed in the CMH hearing summary. Appellant's mother presented evidence of Appellant's daily and weekly schedule. (Exhibit 2) Appellant's mother testified that she was on bed rest all of ██████████ and had an emergency C-section in ██████████ and has been on lifting restrictions ever since. Appellant's mother opined that CMH had documentation of these limitations when they made their decision in this matter.

Appellant's mother also provided at the hearing documentation of her recent medical problems as well as those of her husband's. (Exhibit 2) Appellant's mother testified that she is Appellant's primary caregiver and that she does take care of her child.

Appellant bears the burden of proving by a preponderance of the evidence that an additional 100 hours of CLS per month are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing 100 hours per month of CLS for Appellant, and in denying an additional 100 hours of CLS per month. Appellant failed to prove by a preponderance of the evidence that an additional 100 hours per month of CLS was medically necessary.

As indicated above, B3 services are not intended to meet all of a consumer's needs and preferences and it is reasonable to expect parents of minor children with disabilities to provide the same level of care they would provide to children without disabilities. Here, prior to the hearing, the CMH had received no information indicating that there had been a change in Appellant's condition, or the condition of his parents, that would indicate a need for such an increase in CLS hours. As such, the CMH properly based its decision on the information submitted with the request for additional CLS hours and, based on that information, it properly determined that the current amount of CLS authorized is sufficient in amount, scope and duration to reasonably meet the goals listed in Appellant's PCP. Appellant is always free to make another request to CMH for additional services, but should ensure that the request includes documentation regarding Appellant's parent's conditions and limitations as well as any changes in Appellant's condition.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for an additional 100 CLS hours per month.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

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cc:



Date Signed: October 24, 2013

Date Mailed: October 24, 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.