

**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. 2014-19372 CMH  
Case No. ██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on his own behalf. His witnesses were ██████████, ██████████ County and ██████████, CLS Coordinator, ██████████ County.

██████████, Customer Service, CMH Services of ██████████ County represented the Department (CMH or Department). ██████████, Community Placement Coordinator and ██████████, Recipients Rights Officer, appeared as witnesses for the CMH.

**ISSUE**

Did the CMH properly reduce Appellant's Community Living Supports (CLS) hours from 10 to 7 hours per week?

**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 1; 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 hearing and sight impaired and has had numerous surgeries over his lifetime. (Testimony)

3. Appellant lives alone in his own home, but does spend a lot of time with his girlfriend. (Testimony)
4. A progress note from ██████████ indicates that Appellant was more comfortable with riding the bus. (Exhibit 7; Testimony)
5. On ██████████, as the CLS authorization period was ending, Appellant's Supports Coordinator determined that Appellant's CLS hours should be decreased from 10 to 7 hours per week because 121 hours of CLS had been expended in the prior period to train Appellant on how to ride the bus. (Exhibit 8; Testimony). Given the training, the Supports Coordinator determined that continued CLS hours for this purpose were no longer medically necessary. (Exhibit 1, Testimony)
6. On ██████████, Appellant's Supports Coordinator completed an Addendum to Appellant's Plan of Service reflecting the reduction in CLS. (Exhibit 2; Testimony)
7. On ██████████, Appellant was notified via Adequate Action Notice of the reduction in CLS hours. (Exhibit 5; Testimony)
8. Appellant's request for a hearing was received by the Michigan Administrative Hearing System on ██████████. (Exhibit A)

### **CONCLUSIONS OF LAW**

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

*42 CFR 430.0*

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of 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.

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.

*October 1, 2013, pp 112, 114-115.*

Appellant's Supports Coordinator testified that on ██████████, as the CLS authorization period was ending, he determined that Appellant's CLS hours should be decreased from 10 to 7 hours per week because 121 hours of CLS had been expended in the prior period to train Appellant on how to ride the bus. Given the training, the Supports Coordinator determined that continued CLS hours for this purpose were no longer medically necessary. Appellant's Supports Coordinator indicated that a progress note from ██████████ indicated that Appellant was more comfortable with riding the bus. Appellant's Supports Coordinator testified that on ██████████, he completed an Addendum to Appellant's Plan of Service reflecting the reduction in CLS and on ██████████, Appellant was notified via Adequate Action Notice of the reduction in CLS hours.

Appellant testified that he feels that he still needs the additional CLS hours. Appellant indicated that while he is improving on riding the bus, he could use the additional CLS hours to learn more locations and become more comfortable riding the bus. Appellant indicated that he would like his CLS hours to be continued at 10 hours per week for another 6 months for this purpose.

Appellant's CLS Coordinator at the ██████████ County testified that it takes a long time to train someone to ride the bus, and while Appellant has made progress, additional hours for this purpose would be helpful.

Appellant bears the burden of proving by a preponderance of the evidence that the reduction in his CLS hours was inappropriate. Based on the evidence presented, Appellant failed to meet this burden. The CMH presented competent evidence that at least 3 hours per week of CLS in the prior period had been used for training Appellant to ride the bus and that Appellant was now comfortable in riding the bus. As such, those 3 hours would no longer be medically necessary. Furthermore, as the CMH witness pointed out, the reduction in CLS does not preclude Appellant from using any of the remaining 7 CLS hours per week to work on riding the bus.

As indicated above, B3 services are not intended to meet all of a consumer's needs and preferences. Here, the current amount of CLS authorized is sufficient in amount, scope and duration to reasonably meet the goals listed in Appellant's amended PCP.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's CLS hours from 10 to 7 per week.

**IT IS THEREFORE ORDERED** that:

The CMH decision is **AFFIRMED**.



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

[REDACTED]  
cc: [REDACTED]

Date Signed: February 18, 2014

Date Mailed: February 18, 2014

**\*\*\* 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.