

**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. 2014-22032 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 ██████████, Guardian and Sister, represented the Appellant. ██████████, Mother, appeared as a witness for the Appellant. ██████████, Hearing Officer, represented ██████████th ("CMH" or "Department"). ██████████, DD Services Supervisor, and ██████████, Behavioral Support Specialist, appeared as witnesses for the CMH.

**ISSUE**

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

**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, mood disorder, and mental retardation. (Exhibit 1, page 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 ██████████
4. The Appellant lives in his own home and is involved in the self-determination program. The Appellant's family hires and supervises all of the staff that provide services to the Appellant.

██████████  
**Docket No. 2014-22032 CMH**  
**Decision and Order**

5. The Appellant previously received █████ hours per day of CLS services.
6. On █████, a review of services was completed and based on medical necessity, it was determined that there should be a reduction in CLS services to █████ hours per day. (Exhibit 2)
7. On █████, an Action Notice and Hearing Rights was sent to the Appellant's Guardian regarding the proposed reduction of CLS hours. (Exhibit 3)
8. On █████, the Michigan Administrative Hearing System (MAHS) received a hearing request filed on behalf of the Appellant. On █████ the hearing request was re-submitted with documentation of Guardianship.

**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

**Docket No. 2014-22032 CMH**  
**Decision and Order**

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.

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

**Docket No. 2014-22032 CMH**  
**Decision and Order**

- 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.

*Medicaid Provider Manual  
Mental Health and Substance Abuse Section,  
October 1, 2013, Pages 12-14*

Regarding CLS through the Habilitation Supports Waiver, the Medicaid Provider Manual states:

## **15.1 WAIVER SUPPORTS AND SERVICES**

### **Community Living Supports (CLS)**

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.

**Docket No. 2014-22032 CMH**  
**Decision and Order**

- Assistance, support and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.
  
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, 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 DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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

██████████  
**Docket No. 2014-22032 CMH**  
**Decision and Order**

PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. 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.

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. 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,  
October 1, 2013, Pages 89-90*

The Appellant's mother and sister disagree with the reduction to the Appellant's CLS services from █ hours per day to █ hours per day. They asserted the reduction in the Appellant's behaviors was due to the services he was receiving, particularly including the CLS staff on the two to one basis. They testified that it feels like the Appellant is being punished for doing well, and are concerned that it is not in the Appellant's best interests to cut the staffing now. With only one to one staffing, the staff person is more limited in the ability to address and respond to problems. This is of particular concern when staff is driving the Appellant in his van to an appointment or outing in the community. The Appellant is █ tall, weighs █ pounds, and is independent with mobility. The Appellant has attacked a lone staff person in a vehicle in the past. The staff does not feel safe taking the Appellant out in public with one to one staffing. It is expected that when the staff will now end up telling the Appellant they cannot go somewhere that he wants to go, this alone will cause an increase in the Appellant's behaviors.

The CMH asserts that the new Individual Plan of Service (IPOS) for the Appellant with the reduction to █ hours per day of CLS is sufficient to reasonably meet the Appellant's needs. The DD Services Supervisor testified that the Appellant's behaviors have decreased and he has done well. The DD Services Supervisor feels that the



**Docket No. 2014-22032 CMH**  
**Decision and Order**

█ to one intervention, there is no longer medical necessity for a continued authorization of █ hours per day of CLS services. The authorized █ hours per day should be sufficient to meet the Appellant's needs. The available information supports the CMH determination to reduce the Appellant's CLS authorization.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly reduced the Appellant's CLS authorization.

**IT IS THEREFORE ORDERED** that:

The CMH decision is **AFFIRMED**.

/s/

Colleen Lack  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: █

Date Mailed: █

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**\*\*\* 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.