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:

Docket No. 2014-401 CMH

[redacted] [redacted] [redacted]

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 request for a hearing filed on behalf of Appellant.

After due notice, a hearing was held on [redacted] [redacted], Appellant's brother and legal guardian, appeared and testified on Appellant's behalf. [redacted], Assistant Corporation Counsel, represented Respondent [redacted] (the "CMH"). [redacted], Access Center Supervisor, testified as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for Community Living Supports (CLS)?

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 CMH is under contract with the Department of Community Health (DCH) to provide specified Medicaid-covered services to people who reside in the CMH's service area.

2. Appellant is a [redacted] year-old who has been diagnosed with schizophrenia, paranoid type. (Respondent's Exhibit A, page 11).

3. Appellant lives with his representative/brother and the representative's family. Appellant's representative is also his court appointed guardian. (Respondent's Exhibit A, pages 12, 19).

4. On [redacted], the CMH performed an initial intake after Appellant's representative/guardian requested services on his behalf. (Respondent's Exhibit A, pages 11-29).

5. On [redacted], a meeting was also held as part of the process of developing Appellant's person centered plan. (Respondent's Exhibit A, pages 39-45).

6. At that time, it was noted that Appellant receives Adult Home Help Services (HHS) through another Medicaid program overseen by DCH and the Michigan Department of Human Services (DHS). (Testimony of Appellant's representative; Testimony of [redacted]).

7. Following that intake and meeting, the CMH authorized supports coordination, fiscal intermediary services, and respite care services for Appellant. The respite care services were approved in the amount of [redacted] hours per week. (Respondent's Exhibit A, pages 42-43; Testimony of Appellant's representative).

8. Appellant and his representative/guardian had also requested CLS through the CMH. However, that portion of the request was denied. (Respondent's Exhibit A, page 7).

9. On [redacted], the CMH sent Appellant's guardian written notice that the request for CLS was denied. Specifically, the denial stated: "Skill development is one of the primary functions of CLS. In this case, CLS is providing direct care. Please reference MCCMH Policy 2-007 Section B Conflict of Interest." (Respondent's Exhibit A, page 7).

10. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing regarding the denial of CLS. (Respondent's Exhibit A, page 9).

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*

Moreover, 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.

The CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Among the services that can be provided by the CMH are CLS and, with respect to CLS, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **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:
>
> > 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 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 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.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 114-115

However, while CLS are Medicaid-covered services, Medicaid beneficiaries are only entitled to medically necessary covered services for which they are eligible and 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.

With respect to medical necessity, the MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 12-13, provides:

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.

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

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.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 111-112

Here, while authorizing other services such as supports coordination and respite care, the CMH denied Appellant's request for CLS. Appellant has appealed that denial and, in doing so, bears the burden of proving by a preponderance of the evidence that the

CMH erred. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

According to Appellant's representative/guardian, he was seeking CLS in order to receive more assistance for his and his family in caring for Appellant, who requires around-the-clock care. However, CLS is not meant to provide such general care. Instead, CLS are only to be used "to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 114). Similarly, B3 supports and services in general are only intended to "to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 110). Here, Appellant's plan contains no such goals. Appellant's representative also testified that he did not ask and does not want such assistance in this case.

Moreover, Appellant is already receiving HHS and CLS cannot supplant such services. (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 113). To the extent Appellant requires more hands-on assistance with personal care activities, his representative can always request more HHS or Expanded Home Help through DHS.

As described in the above policy, B3 supports and services, such as CLS, "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." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 111). Moreover, in allocating such services, the CMH "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 111).

Here, taking into account those policies; the reasons for which Appellant's representative/guardian seeks CLS; Appellant's natural supports; and the significant services Appellant already receives; this Administrative Law Judge finds that Appellant has failed to meet his burden of proof with respect to the denial of CLS. Accordingly, the CMH's decision is affirmed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.

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

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** 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.