STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF

Docket No. 15-013660 CMH
Case No.

Appellant

______________________/

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's mother, appeared and testified on Appellant's behalf.

(P) represented Respondent (CMH or Department or Respondent). , Case Manager and , Child and Family Supervisor appeared as witnesses for the Department.

ISSUE

Did the CMH properly calculate Appellant's Community Living Supports (CLS) hours?

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 Medicaid beneficiary and is a minor child.

2. Appellant has been diagnosed with Autism Spectrum Disorder.

3. CMH is under contract with the Department of Health and Human Services (DHHS) to provide Medicaid covered services to people who reside in the CMH service area.

4. Appellant is a year old Medicaid beneficiary, born . He resides half-time with his mother and father. He attends school at five days per week.

5. On , CMH conducted an Annual Clinical Assessment.

(Respondent's Exhibit 1)

6. Appellant had been receiving 31 hours of Community Living Services (CLS) and 30 hours of Respite Care (RC) per month.

7. On [redacted] CMH authorized 20 hours per week of CLS but no RC.

8. On [redacted] CMH authorized six hours of RC in addition to the 20 hours of CLS.

9. On [redacted], Notice was sent to Appellant's mother of the approval for 20 hours of CLS and 6 hours of RC.

10. On [redacted], Appellant's mother filed a request for a hearing to contest the CMH negative action.

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 *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to community living supports:

> **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.).
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> Coverage includes:
>
> - Assisting, reminding, 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.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
January 1, 2014, pp 113-114.

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> 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.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
January 1, 2014, Page 111

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 that are needed to reasonably achieve his goals.

The CMH's representative testified that the purpose of CLS is skill building and that CLS is not intended to meet all the needs of the beneficiary. Appellant's goal is that he will be

successful with social interactions at home and in the community. The CLS were reduced because Appellant now spends 50% of his time with his father and mother. Before, Appellant was primarily living with his mother. Appellant was making progress. He had good verbal skills and more natural supports. He is in school all day and able to be with both parents and grandparents for caregiving.

CMH contends that 20 hours of CLS per week is sufficient for Appellant to reach his objectives. Increasing the number of hours is clinically unlikely to produce a corresponding increase in safety skills. In short, additional hours of CLS would be ineffective as an intervention. CMH has the authority under Section 2.5 of the Medicaid Provider Manual to deny a requested service on the grounds that it would not be clinically effective.

CMH further contends that additional hours of CLS cannot be expected to treat, ameliorate, diminish or stabilize the symptoms of Appellant's developmental disability, or assist the beneficiary to attain or delay progression of his developmental disability, or assist the beneficiary to attain or maintain a sufficient level of functioning to meet his objective. In short, any additional hours of CLS would not meet medical necessity criteria set forth in Section 2.5A of the Medicaid Provider Manual. Lastly, summer camp is no longer offered as CMH benefit.

Appellant's mother contends that she paid for summer camp for Appellant so that he did not regress when he was not in school in the summer. Appellant loses ground in the summer and he is at a critical developmental stage where he would receive benefit from increasing his community support hours. She did not see much difference in his prior annual assessment which would justify the reduction in Appellant's CLS hours.

Based on the evidence presented, Appellant has failed to meet her burden of proof to show, by a preponderance of evidence, that the currently offered amount of CLS is insufficient to meet her needs. As indicated above, Appellant is currently being offered 20 CLS hours per week. While it is understandable that Appellant's family has concerns with the hours offered by CMH, the fact remains that if there are no issues with CLS staff, Appellant will be receiving the 20 hours of CLS per week that her family desires for Appellant. CMH indicates that Appellant now spends more time with family members as natural community supports and that he has made sufficient progress that his needs can be met with the reduced hours. Based on Appellant's current IPOS, 20 hours of CLS hours between per week is sufficient in amount, scope and duration to meet Appellant's medically necessary needs.

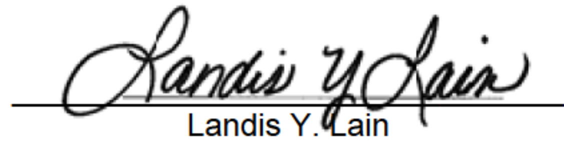
CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Appellant should receive 20 hours per week in Community Living Service hours based upon his current circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly determined that Appellant is eligible for 20 CLS hours per week.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.



Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc:

LYL/

Date Signed: October 13, 2015

Date Mailed: October 13, 2015

***** 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.