

**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. 15-010676 CMH

██████████
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 parents, appeared and testified on Appellant's behalf. Appellant also attended the hearing.

██████████ represented Respondent, ██████████ (CMH or Department). ██████████, IDD Child and Family Supervisor, appeared as a witness for the CMH.

ISSUE

Did the CMH properly calculate Appellant's Community Living Supports (CLS) and Respite Care Services (RCS)?

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 ██████████ who has been receiving supports and services through CMH. (Exhibit 1, p 1; Testimony).
2. CMH is under contract with the Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibits 1-4; Testimony)
3. Appellant is diagnosed with infantile cerebral palsy, is wheelchair bound, and requires assistance with all of her care needs, including feeding, toileting, bathing, dressing, and transferring. Appellant is non-verbal, but is able to communicate with her Echo 2 device, attached to her wheelchair. (Exhibit 1, pp 1, 8; Testimony)

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4. Appellant lives with her adopted parents in the family home, which includes ■ other adults and ■ other child with disabilities, as well as the family's adult ■ who lives in the lower level of the home and is able to help care for the ■ physically impaired individuals. Appellant's adopted mother is also wheelchair bound and is not able to help with any of Appellant's physical care. (Exhibit 1, pp 1-2; Testimony).
5. Appellant's natural supports consist of her ■, ■, and ■ and ■. (Exhibit 1, p 1; Testimony)
6. Appellant attends ■, where she is partially mainstreamed. Appellant receives physical, occupational, and speech therapy through the school and has a one to one aide. (Exhibit 1, p 1; Testimony)
7. On ■, an Annual Clinical Assessment was conducted in Appellant's home. (Exhibit 1, pp 1-9)
8. On ■, an Individual Plan of Service Meeting was held at Appellant's home. (Exhibit 3, pp 1-6)
9. On ■, CMH sent Appellant an Adequate Action Notice indicating that her CLS hours were being reduced from ■ hours per month to ■ hours per month and that her RCS were being reduced from ■ hours per month to ■ hours per month. (Exhibit 4, p 1; Testimony)
10. On ■, Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (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

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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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services 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 (MPM), Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan.

The MPM states with regard to medical necessity:

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.

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;
 - that are 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 Chapter
April 1, 2015, pp 12-14

The MPM states with regard to community living supports:

17.3.B. COMMUNITY LIVING SUPPORTS

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

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 services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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

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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.

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, sensory motor, 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 Chapter
April 1, 2015, pp 122-123

With regard to Respite Care Services (RCS), the Medicaid Provider Manual indicates:

17.3.I. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used.

Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

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- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

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Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

*Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
April 1, 2015, pp 132-134*

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services through which Appellant receives Respite Care Services (RCS), is not intended to meet every minute of need for beneficiaries:

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. (Emphasis added).

*Medicaid Provider Manual
Mental Health and Substance Abuse Section
April 1, 2015, p 120*

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CMH's Supervisor testified that she has been in her current position since ██████████ and that as a supervisor she reviews requests for services submitted by supports coordinators on behalf of beneficiaries and makes determinations regarding the medically necessary level of services. CMH's Supervisor indicated that in the instant case she reviewed Appellant's Annual Clinical Assessment, her IPOS, her goals, met with staff, and concluded that Appellant could meet the goals in her IPOS with █ CLS hours per week. CMH's Supervisor testified that the additional █ CLS hours Appellant previously received were not necessary to meet the objectives in her treatment plan. With regard to RCS, CMH's Supervisor testified that the reduction from ████████ to █ RCS per month was mostly due to budget constraints and that, as a B3 service, the CMH had the responsibility to ensure that they would be able to equitably serve other beneficiaries in need of RCS services.

Appellant's father testified that he was very thankful for the services that CMH provides, but that Appellant is very intelligent, goes to a regular school, and could benefit from even more CLS, not less. Appellant's father indicated that the family was seeking an additional █ CLS hours per month, not just the reinstatement of the █ CLS hours per month they recently lost. Appellant's father testified that he understood the cut in RCS because of budget constraints, but that the family had been hoping to use some of the RCS hours for CLS because Appellant benefits so much from the CLS hours. Appellant's father indicated that Appellant has the ability to learn, is able to use her Echo device to communicate and can use it to go on the Internet and participate on ██████████ and other programs. However, Appellant's father testified that to do these things Appellant needs assistance and he and the family are only able to provide so much. Appellant's father testified that the fact that Appellant returned to school this fall with higher reading and comprehension shows that she did benefit from, and would continue to benefit from, additional CLS hours. Appellant's father testified that as it stands now, Appellant is only able to be bathed ████████ per week because that is all that is allowed for with the current allotment of CLS hours – if Appellant were bathed every day, it would take all of her CLS hours and there would be no time left for learning and community integration. Appellant's father indicated that at the current level of CLS, Appellant's community involvement is very limited, but that since Appellant is now in high school, there are more and more opportunities available that she is missing out on. Appellant's father also indicated that he is not getting any younger and it is more and more difficult for him to care for his daughter.

Appellant's mother testified that Appellant is a typical █ year old girl, is concerned about her appearance and hygiene, and she should not have to be bathed by her father.

Based on the evidence presented, it is determined that Respondent followed proper policy in determining the number of medically necessary CLS and RCS hours for Appellant. The clinician who completed the utilization review took into account Appellant's needs and the specific goals in her IPOS. One of the goals in Appellant's IPOS is to "... increase her community integration all the while continuing with her academics and personal independence, which will help with proper socialization." The objective associated with this goal is that the beneficiary "... will work on her 1) head/eye coordination for small motor activities (Wii, iPad, wiping the counter) and also so she can maneuver her chair safely in various parts of her body on a daily basis." Certainly, that limited objective can be met with █ CLS hours per week,

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especially now that Appellant is back in school full-time. Based on the information the CMH had at the time of the decision, the decision was supported by the evidence in the record.

With regard to RCS, Respondent has a mandate to allocate the limited funds it receives from the State to provide services to all eligible persons in its service area and the reduction in Appellant's RCS was due to budget constraints. Appellant's parents did not take much issue with the reduction in RCS, except in that they had hoped to use some of the RCS hours towards CLS. Here, the reduction in RCS was in conformance with policy.

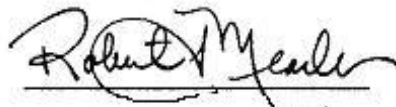
Appellant bears the burden of proving by a preponderance of the evidence that additional CLS and RCS are medically necessary. Based on the foregoing analysis, Appellant has failed to meet that burden.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.



Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [REDACTED]
Date Mailed: [REDACTED]
RJM/db
cc: [REDACTED]
[REDACTED]
[REDACTED]
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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.