**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**
P. O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax (517) 373-4147

**IN THE MATTER OF:**

**MAHS Docket No.** 15-019972 CMH

[redacted],

Appellant

[redacted]/

## 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 Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on his own behalf. [redacted] Appellant's case worker/supports coordinator at [redacted] also testified as a witness for Appellant. [redacted], Assistant Corporation Counsel, represented the Respondent [redacted] (CMH). [redacted] Clinical Supervisor, testified as a witness for the CMH.

## ISSUE

Did Respondent properly deny Appellant's request for additional 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. Appellant is a t[redacted]-year-old Medicaid beneficiary who has been diagnosed with generalized anxiety disorder; congenital diplegia; spina bifida; muscle spasms; and pure hypercholesterolemia. (Exhibit A, page 9).

2. Through the Department of Health and Human Services (Department or DHHS), Appellant had been authorized to receive [redacted] hours and [redacted] minutes of Home Help Services (HHS) per month. (Exhibit A, pages 40-45).

3. Appellant has been receiving services through the CMH, including supports coordination; occupational therapy; physical therapy; and [redacted] hours of CLS per week. (Exhibit A, page 17; Testimony of CMH's Clinical Supervisor).

4. On [redacted], an Annual Assessment was held with respect to Appellant's needs and services. (Exhibit A, pages 9-35).

5. During that assessment, Appellant reported that his HHS had recently ended and he was requesting an additional [redacted] hours per month of CLS. (Exhibit A, page 17).

6. On [redacted], the CMH sent Appellant written notice that his request for additional CLS was denied on the basis that the additional hours were not medically necessary. (Exhibit A, page 5)

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing in this matter. (Exhibit 1, pages 1-2).

## 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 statutes, 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*

Additionally, 42 CFR 430.10 states:

> 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 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 Health and Human Services (DHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Here, Appellant has been receiving CLS and, with respect to such services, the Medicaid Provider Manual (MPM) provides in part:

> **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 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.
>
> *MPM, July 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 122-123*

However, while CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM 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
> - 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.

*MPM, July 1, 2015 version*
*Mental Health/Substance Abuse Chapter, pages 12-14*

Moreover, 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. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

## 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, 2015 version*
*Mental Health/Substance Abuse Chapter, pages 119-120*

Here, it is undisputed that Appellant requires some CLS and it is only the amount of hours to be authorized that is at issue, with the CMH authorizing [redacted] hours per week of such services and denying Appellant's request for an additional [redacted] hours per week of CLS.

In support of that decision, the CMH's Clinical Supervisor testified that, per policy, CLS cannot supplant HHS and that Appellant must request HHS if assistance with activities of daily living and instrumental activities of daily living are needed. She also testified that Appellant was receiving HHS in this case and the fact that such services ended does not justify additional CLS. According to the CMH's witness, if Appellant voluntarily ended his HHS, then his actions would violate the above policy and, if his HHS were terminated, then the CLS would also not be medically necessary.

In response, Appellant's supports coordinator testified that Appellant's HHS stopped because he does not currently have an enrolled home help provider and that she and Appellant are trying to resolve the issue. However, she also testified that, given Appellant's progress, his HHS assessment and authorization is no longer accurate and he needs less hands-on assistance and HHS than before. She also testified that Appellant instead needs more CLS and training. In particular, she testified that Appellant can be trained to do almost everything independently. Appellant also testified that he is getting more independent in all personal tasks.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying his request for additional CLS. Given the record and evidence in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet that burden of proof and that the CMH's decision must therefore be affirmed. As noted by Appellant's witness, HHS and CLS serve different needs and goals, and, to the extent the CMH's notice of denial or its witness' testimony suggests that CLS could not be necessary if HHS was no longer necessary, the CMH is incorrect. However, while Appellant and his representative argue that Appellant needs more CLS to assist him in training and guiding in personal care tasks, which can be a proper use of CLS, they fail to demonstrate any medical need for such additional assistance. Appellant already receives approximately [redacted] hours per day of CLS and the record is silent as to why such a substantial amount of services is inadequate to meet Appellant's needs or what difference, if any, an additional [redacted] hours per day of CLS would make toward the specific goals in Appellant's plan.

Instead of justifying any specific need for additional CLS, Appellant and his representative appear to argue that the additional CLS is necessary because Appellant no longer requires the hands-on assistance covered by HHS and the hours of HHS should be replaced by CLS. However, the above policy clearly provides that CLS may only complement HHS when the individual's need for assistance has been officially determined to exceed the allowable parameters of HHS and it specifically requires a beneficiary to apply for HHS and, if necessary, Expanded Home Help, first. Accordingly, the mere fact that Appellant's HHS ended does not warrant more CLS on its own and Appellant must continue to pursue HHS. Here, according to Appellant's witness, Appellant's HHS only stopped because he does not have an enrolled provider and, while Appellant and his witness testify that his need for HHS is less than before, there has been no new determination by DHHS regarding Appellant's need for HHS or a basis for the CMH to determine how to complement those HHS with CLS or if more CLS

is necessary. Moreover, while Appellant and his witness also testified that they are in the process of having Appellant's HHS reevaluated and the above policy does provide that CLS may be used for in lieu of HHS while a beneficiary awaits a determination by the Department requiring the amount, scope and duration of HHS or Expanded HHS, that is not what was requested here as Appellant seeks additional CLS on a permanent basis.

With respect to what Appellant does seek, he has also failed to meet his burden of proof for the reasons discussed above and the CMH's decision must be 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 additional CLS.

**IT IS THEREFORE ORDERED** that:

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

Steven Kibit

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

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.