STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

Docket No. 2010-24700 CMH
Case No. [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Attorney, appeared on behalf of the Appellant. The Appellant was not present. Appellant's mother, [redacted], was present and gave testimony on behalf of the Appellant.

[redacted], Fair Hearings Officer for [redacted] County Community Mental Health Authority (CMH), represented the Department's agent CMH. [redacted], Executive Director of Community Living Services, [redacted] County CMHSP (CMH), appeared as a witness for the Department.

ISSUE

Did the Department/Oakland County Community Mental Health Authority properly determine that Community Living Supports was not a Medicaid-covered service during the Appellant's hospitalization?

FINDINGS OF FACT

There is no dispute in this case that Appellant is a [redacted] man with developmental disabilities enrolled in the Habilitation and Supports Waiver Program (HAB). There is no dispute that Appellant has been receiving community living supports (CLS) through the CMH pursuant to his current person-centered plan (PCP).

There is no dispute that Appellant's family recently moved him into his own house, and with the help of CMH found him a roommate who shares authorized CMH CLS and Department of Human Services Home Help Services (HHS) hours to live independently.

There is no dispute that Appellant's PCP authorized CLS services to be provided in his "current living situation" and for recreational services outside the home. (Exhibit 1, pp 13, 17).

There is no dispute in this case that Appellant was hospitalized in [redacted], and that his cost of hospital care was primarily covered by his private [redacted] health insurance.

There is no dispute in this case that Appellant's mother contacted the Appellant's CLS provider agency on or near [redacted] to request CLS services be provided to Appellant in the hospital during his inpatient hospitalization.

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Michigan Medicaid policy defines the types and locations of CLS services for which Medicaid funds can used to pay. (Exhibit 1, pp 5-6).

2. Michigan Medicaid policy limits the purpose of CLS to facilitating an individual's independence and promoting integration into the community. (Exhibit 1, pp 5-6).

3. Acute care inpatient hospitalization is a highly restrictive setting and services provided during a hospitalization are not for the purpose of community integration or recreation outside the home. (Exhibit 1, pp 5-6).

4. Acute care inpatient hospitalization is a highly restrictive setting and services provided during a hospitalization are not for the purpose of individual independence. (Exhibit 1, pp 5-6).

5. Appellant's medical care, personal care and room and board were provided during his acute care inpatient hospitalization and expected to be primarily paid by his [redacted] health insurance. (Exhibit 2).

6. The purpose of CLS does not include provision of services during an acute care inpatient hospitalization and CLS is not a Medicaid-covered service during an acute care inpatient setting. (Exhibit 1, pp 5-6).

7. CMH is prohibited from using Medicaid funds to pay for a non-Medicaid covered service. 42 CFR 440.230.

8. On [redacted], this State Office of Administrative Hearings and Rules (SOAHR) received a request for hearing filed by Appellant's attorney. The request sought Medicaid payment for CLS services while Appellant was hospitalized. (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.

The State of Michigan has opted to simultaneously utilize the authorities under waivers of the Social Security Act, Sections 1915(b) and 1915(c), 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) Medicaid Managed Specialty Services and Support program waiver in conjunction with section 1915(c). The Michigan Department of Community Health contracts with local CMHs to provide Medicaid funded services to persons who meet the criteria for Medicaid funded services.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See 42 CFR 440.230.* 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.* CMH's are required to use a person-centered planning process to identify medically necessary services and how those needs would be met.

The Appellant's mother/witness testified that the Appellant was receiving all his personal care, tube feeding care, and interpersonal interaction at the hospital, but she did not like the frequency of care or some of the ways the care and interaction was performed by hospital staff. (Transcript [Tr.] 65-67). The Appellant's mother/witness admitted that she never notified hospital staff that she did not like the way staff was performing Appellant's tube feeding, diapering, or other care and interaction. (Tr. 67-69). Rather than attempt to resolve her care concerns with the hospital staff, the Appellant's mother called the Appellant's Medicaid CLS provider.

The CMH witness [redacted], Executive Director of Community Living Services testified she made the determination that CMH was prohibited from using Medicaid funds to pay for CMH CLS while the Appellant was hospitalized. Witness [redacted] articulated several reasons for her determination. First Witness [redacted] stated that Appellant lives independently, in a home he shares roommate, and that Appellant also shares CLS services and home help services with a roommate. Witness [redacted] testified that Appellant's PCP authorized him to receive up to [redacted] hours of CLS per week. (Tr. 13-14).

CMH Witness [redacted] testified it was Appellant's mother who called the CLS staffing agency and asked the agency to send someone to be with Appellant while he was in the hospital. (Tr. 14-15, 21). Witness [redacted] stated it was her understanding that Appellant's mother wanted CLS staff to come to the hospital because she did not like

the way hospital staff was providing tube feedings to Appellant. (Tr. 15). Witness [redacted] stated that she did not approve the mother's request to have CLS staff provide services at the hospital after reviewing the parameters of Medicaid-covered CLS as dictated in Department policy, and after reviewing the CLS authorization in Appellant's plan. Witness [redacted] explained that she compared the limits of Medicaid covered CLS to the purpose CLS was being requested -- to supplant the services provided by the hospital because Appellant's mother did not like how hospital staff was providing the care -- and determined the purpose was not a Medicaid-covered service under state Medicaid Policy and therefore was Medicaid payment was prohibited under federal regulations.

The Department's policy with regard to Community Living Supports services is found in the Medicaid Provider Manual, Mental Health and Substance Abuse Service Chapter.

The Department's purpose and coverage description for Habilitations and Supports Waiver Community Living Services is provided in Section 15. B. This policy provides in pertinent part:

> **15.1 WAIVER SUPPORTS AND SERVICES**
>
> **Community Living Supports (CLS)**
>
> Community Living Supports (CLS) facilitate an individual's independence and promote integration into the community. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community
> settings, and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:
>
> - Assisting*, reminding, observing, guiding or training the beneficiary with:
>
> - Meal preparation;
> - Laundry;
> - Routine, seasonal, and heavy household care and maintenance;
> - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
> - Shopping for food and other necessities of daily living.
> - 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 procedure goods other than those listed under shopping and nonmedical 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.

The HSW services cannot supplant Medicaid services. The beneficiary must use the DHS Home Help or Expanded Home Help services for assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene), and shopping.

* CLS services may not supply state plan services, such as Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping in the beneficiary's own unlicensed home). If such assistance is needed the beneficiary, with the help of the PIHP supports coordinator, 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. The PIHP supports coordinator must assist, if necessary, the beneficiary in filling out and sending 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 based on the findings of the DHS assessment.
>
> 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 beneficiary'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 or these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.
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> *Medicaid Provider Manual, Mental Health and Substance Abuse Services, Section 15.1, January 1, 2010, pp 81-82.*

CMH Witness [redacted] testified that she also used the coordination of benefits section to determine whether CLS during hospitalization was a covered benefit (Tr, 22-26). CMH Witness [redacted] explained that when a person enters a medical facility a doctor determines his care needs, a plan of care is developed based on the doctor's determination of needs during the hospital stay and that payment for the hospital care is processed by health insurance for payment. (Tr, 25-26). CMH Witness [redacted] testified that Department policy emphasizes that Medicaid is the payor of last resort; and as Appellant had private [redacted] health insurance to cover the doctor-prescribed hospital care, and as there was no service identified by Appellant's physician outside what the hospital provided, CMH was prohibited from paying. (Tr, 26).

The overview of the Department's policy with regard to Coordination of Benefits is:

> **SECTION 1 – INTRODUCTION**
>
> This chapter applies to all providers.
>
> Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or

> Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.
>
> Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments…
>
> *Medicaid Provider Manual,*
> *Coordination of Benefits, Section 1,*
> *January 1, 2010, p 1.*

As explained by CMH Witness [redacted] when an individual enters a medical hospital he is assigned an attending/managing physician who dictates a plan of treatment of care for the period of hospitalization which stays other plans of care not expressly included. The physician's plan often includes directing staff to continue with a medical regimen of medications, tube feedings and diapering but treatment cannot be performed without physician/hospital authorization.

Appellant argued that CMH terminated his CLS while he was hospitalized but the argument lacks merit. The federal regulations prohibit Medicaid payment for services that do not reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.* Appellant's PCP authorized CLS "to assist him in living independently based on his current living arrangement" (Exhibit 1, p 17). Appellant was not in his independent living setting, rather admitted to an highly restrictive inpatient setting for intensive medical treatment, and therefore the independent living scope and purpose for CLS could not be accomplished as it was authorized in his PCP.

Appellant's PCP also authorized CLS "to be involved in the community and participate in recreational activities." (Exhibit 1, p 13). Appellant's highly restrictive inpatient setting and intensive medical treatment cannot, even by the farthest stretch, be classified as for the purpose of involvement in the community and to participate in recreational activities.

Appellant's argument that CMH terminated his CLS while hospitalized is without legal support. The CMH did not terminate the CLS services; rather, as demonstrated above by fact and law, CLS services are not a Medicaid-covered service during an acute care, inpatient hospitalization. CMH was prohibited from using Medicaid funds to pay for Appellant's CLS while the Appellant was hospitalized. Appellant's characterization of CMH's prohibition from Medicaid payment for CLS during hospitalization is not an accurate characterization.

The federal regulation and state policy prohibit Medicaid funds to pay for services that are covered by a third party. The evidence of record supports the CMH's determination that Medicaid was the payer of last resort and there was no Medicaid-

covered CLS service identified by Appellant's hospital physician beyond what was being provided by the hospital and covered by Appellant's private insurance. As such, the federal regulations prohibited the CMH from using Medicaid funds to pay for CLS during Appellant's hospitalization.

It is important to note that the Appellant's attorney argues that the Appellant's CLS should continue while he is hospitalized but she failed to provide any statute, case law or policy to support her position. The one section of policy Appellant's attorney attempted to pursue during hearing did not apply to Appellant's case because he is enrolled in the HAB waiver and the policy section the attorney relied on was taken from a non-HAB waiver section of policy. (Tr, 28).

The Appellant bears the burden of fact and legal persuasion to establish that CLS services are a Medicaid-covered service to be paid for by Medicaid funds while Appellant hospitalized. The Appellant did not meet this burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Departmen[redacted] County Community Mental Health Authority properly determined that Community Living Supports was not a Medicaid-covered service during the Appellant's hospitalization.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/8/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.