**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],
Appellant
_____/

Docket No. 2010-37647 CMH
Docket No. 2010-40645 CMH

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant.

[redacted], represented the Department. [redacted], appeared as a witness for the Department.

## ISSUE

Did the CMH properly deny the Appellant's request for speech therapy and occupational therapy services because those services were covered under his private [redacted] insurance?

Did the CMH properly deny the Appellant's request for additional respite and community living supports 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. The Appellant is a Medicaid beneficiary receiving services through [redacted] (CMH).

2. CMH is under contract with the Department of Community Health (MDCH)

to provide Medicaid covered services to people who reside in the CMH service area.

3. The Appellant is a [redacted] Medicaid beneficiary. The Appellant has autism. (Exhibit D).

4. The Appellant lives with his father and mother in an unlicensed setting.

5. Appellant's mother is his primary caregiver.

6. The CMH currently authorizes the following Medicaid services for Appellant: 12 hours per week for respite and 15 hours per week for CLS. (Exhibit C).

7. On [redacted], the Appellant's mother-representative at hearing requested an additional six hours per week of respite services and three hours per week of CLS services, for a total of 18 hours of CLS per week and 18 hours of respite per week.

8. On [redacted], the CMH denied the request for additional respite and CLS hours, and mailed an adequate action notice that included rights to a Medicaid fair hearing. (Exhibit B).

9. In [redacted] the Appellant's mother requested speech and occupational therapy for the Appellant.

10. In [redacted] CMH denied their request for speech and occupational therapy because those services were covered in Appellant's private [redacted] insurance certificate of coverage.

11. The Appellant's requests for hearing were received by this office on [redacted] and [redacted], and processed under two separate docket numbers. (Exhibit D).

## 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.

**Speech therapy and occupational therapy services issue**

The CMH representative and witness [redacted] stated during the hearing that Medicaid is the payer of last resort and CMH was prohibited from authorizing speech and

occupational therapy because speech and occupational therapy were covered under the Appellant's [redacted] insurance policy. CMH witness [redacted] testified that the CMH obtained a copy of Appellant's [redacted] certificate of coverage and the terms of the certificate indicated speech and occupational therapy were covered. The CMH representative explained that Medicaid policy would allow CMH to cover the therapies if the Appellant produced evidence that the [redacted] insurance did not cover speech and occupational therapy. On [redacted], the CMH representative provided written notification to this State Office of Administrative Hearings and Rules for the Department of Community Health informing it that it received documentation from Appellant's parent's employer clarifying [redacted] coverage and it was the decision of the CMH to authorize two hours per week of occupational therapy and two weeks of speech and language services from [redacted] through [redacted]. With CMH authorization of the speech and occupational therapy the Appellant's first issue is resolved.

**Appellant's request for additional respite and community living supports hours**

The evidence of record shows that the Appellant's person centered plan currently authorized 15 hours of CLS per week and 12 hours of respite services per week. (Attachment C). On [redacted], the Appellant's mother-representative requested an additional six hours per week of respite services and three hours per week of CLS services, for a total of 18 hours of CLS per week and 18 hours of respite per week.

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 respite and community living supports:

> **17.3.J. RESPITE CARE SERVICES**
>
> Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary care giver. Decisions about the methods and amounts of respite should be decided during person-centered planning.
>
> *April 1, 2010, Pages 110 and 111.*

## 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, 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 nonmedicalservices

- 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. (Underline emphasis added by ALJ).

*April 1, 2010, Page 60.*

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. (Exhibit J).

The CMH witness [redacted] testified that Appellant was assessed to determine what services each needed and a determination of medically necessary Medicaid services in

the amount of 12 hours per week for respite and 15 hours per week for CLS. (Exhibit C). [redacted] explained that after receiving the request for an increase in respite and CLS hours, the CMH reviewed the reason that Appellant's mother-representative asserted for those extra hours. [redacted] further explained that the reasons provided for additional CLS hours were so the Appellant would not "lose any skills that he had learned," and the reasons provided for additional respite hours were so Appellant's mother-representative could "get things done around the house." (Exhibit H). [redacted] testified that the increase in additional CLS and respite hours were denied because there was no evidence presented with the request to establish that the Appellant would lose any skills. (Exhibit A).

The Appellants' mother testified that the Appellant needs to be watched 24 hours a day. The Appellant's mother testified that the CLS and respite hours are not typically divided up during the week rather they are used consecutively over weekends so her husband, who works nights during the week, can sleep during the day while she is at work. As noted above and Medicaid policy, respite can only be used to relieve the unpaid caregiver, here the Appellant's mother, and cannot be used to allow a parent to work.

The Appellant bears the burden of proving by a preponderance of the evidence that the additional three hours of CLS and six hours of respite are medically necessary. The Appellant's mother was asked to provide specific examples of how that exact amount of increase is medically necessary. The Appellant's mother stated that during the summer the additional respite hours could be used to cut the grass or do things around the house while a respite or CLS worker was watching the Appellant. The testimony of the Appellant's mother was not specific enough to establish medical necessity above and beyond the number of respite and CLS hours CMH assessed in accordance to the Code of Federal Regulations (CFR).

The CMH must authorize respite services in accordance to the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when authorizing respite 12 hours per week for respite and 15 hours per week for CLS for the Appellant. The Appellant failed to prove by a preponderance of the evidence that the additional hours of respite and CLS are medically necessary.

## DECISION AND ORDER

The Appellant's first issue was resolved during and immediately following the hearing.

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied hours in addition to the 15 hours per week for respite and 15 hours per week for CLS for the Appellant.

**IT IS THEREFORE ORDERED** that:

The CMH decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 8/20/2010

***** 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.