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. 2010-45610 CMH
Case No. [redacted]

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], and [redacted], appeared on behalf of the Appellant. [redacted] was also present.

[redacted] (CMH), represented the Department's agent-CMH. [redacted] and [redacted], appeared as witnesses for the CMH.

ISSUE

Did the CMH properly authorize the Appellant's 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 is diagnosed with moderate mental retardation, epilepsy, and diabetes. (Exhibit 2, page 2 of 22).

4. The Appellant receives her CMH services through self-determination. The Appellant's fiscal intermediary is [redacted]. (Exhibit 2, page 2 of 22).

5. The Appellant lives with her father and mother. (Exhibit 1, page 2 of 22; Exhibit 2, page 5 of 23).

6. Appellant's mother is her paid Department of Human Services Home Help Services (HHS) chore provider. Appellant's mother is paid by Medicaid to provide 11 hours a week or 1.6 hours per day of HHS personal care to the Appellant.

7. Appellant's [redacted] person centered plan (PCP) authorized CMH services from [redacted], through [redacted]. (Exhibit 2). Included in the [redacted] PCP was authorization for 46 hours per week of CLS, three respite days (including overnight) per month, 350 miles per month transportation, and skill-building, supports coordination and fiscal intermediary services. (Exhibit 2, page 23 of 23).

8. Appellant's [redacted] through [redacted] PCP authorized Medicaid services for the following: CLS goal for community transportation, and safety in the community. (Exhibit E).

9. In or around [redacted], the CMH performed a review of the Medicaid-covered services the CMH proposed to authorize for Appellant in her [redacted] PCP, including documentation to support the medical need for services.

10. During the review the CMH noted that one of the CLS goals Appellant had been approved, learning to use community transportation, was not worked on in [redacted]. (Exhibits 1 and 2).

11. Because learning to use community transportation was paid for by Medicaid but not utilized by the Appellant, the CMH did not include the safety authorization in the [redacted] PCP authorization.

12. During the review the CMH noted that safety goals for which Medicaid was paying for were already provided in the CLS authorization and therefore were duplicative.

13. Because safety awareness is included in any community participation event, for example community outings to the library, the CMH did not include the safety authorization in the [redacted] PCP authorization.

14. During the review the CMH increased CLS authorization for meal planning and preparation, for telling time on an analog clock, and for increasing reading skills.

15. During the review the CMH continued its authorization of three days per week at a vocational center and transportation to and from the vocational center. (Exhibit 1, pages 2 and 3 of 22).

16. On or around [redacted], the Appellant and CMH finalized the PCP.

17. On or around [redacted], the CMH sent the Appellant the finalized [redacted] PCP. Included in the [redacted] PCP was authorization for 36 hours per week of CLS, two respite days (including overnight) per month, 320 miles per month transportation to community and skill-building, supports coordination and fiscal intermediary services. The [redacted] PCP included an Adequate Action Notice to the Appellant that informed of the rights to a Medicaid fair hearing. (Exhibit 1, page 20 of 22).

18. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on [redacted]. (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*

> 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 she 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) 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 Appellant has chosen to receive her CMH services through self-determination. In self-determination the Code of Federal Regulations (CFR) requirement (cited above) for appropriate scope, duration, and intensity remained intact. In self-determination cases specific Medicaid covered services need to be identified and specific time needs to be established for each service. Although the services must be authorized in an amount scope and duration that reasonably meets the need, services must be related to the need and must be authorized in objective increments.

Community Living Supports Authorization

The CMH witness [redacted] testified that she and other CMH staff reviewed the services utilized by the Appellant and compared it to the services authorized in the person centered plan the previous year, [redacted]. Upon comparison the CMH staff noticed that some services were duplicated, (safety), and some had never been utilized, (training for public transportation). For this reason witnesses [redacted] testified that the CMH did not include the authorizations for those two items for [redacted]. The CMH authorized additional services in [redacted] that had not been authorized in [redacted] (for meal planning and preparation, for telling time on an analog clock, and for increasing reading skills). Community vocational rehabilitation was continued at the same level of three days per week, including transportation.

Despite the authorization of services not previously authorized in [redacted], the difference in overall hours between the [redacted] PCP and [redacted] PCP was 10 less hours in the [redacted] PCP.

The Appellant's mother testified that the Appellant will regress if her overall time is reduced. The Appellant's mother was not able to identify or relate a specific service reduction that would lead to the regression. The Appellant's mother testified that they had not worked on training for public transportation.

The [redacted] PCP authorized payment for the transportation training and Medicaid dollars were spent assuming the training had occurred. The CMH is prohibited from authorizing community mental health dollars to pay for services that are not provided. The Appellant's mother further testified that she was aware of the duplication of safety services. Again, the CMH must not use Medicaid dollars to pay for services that are duplicated.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. It 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.).
>
> 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 she/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.

MPM, Mental Health and Substance Abuse Section, July 1, 2010, Page 100.

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary, and to determine the amount or

level of the Medicaid medically necessary services that are needed to reasonably achieve her goals.

Applying the facts of this case to the documentation in the annual PCP assessment supports the CMH position that Appellant had goals which were not pursued in [redacted] and would not be pursued in [redacted], and had goals that were duplicative. In other words, the difference in hours from the previous PCP was not due to a change in Appellant's condition, rather that she had had CLS hours approved for non-Medicaid-covered goals in the previous PCP. Medicaid cannot cover non-utilized or duplicative services. The CMH properly authorized non-duplicated services that would be utilized in Appellant's [redacted] PCP at 36 hours per week.

Authorization of Respite Services

The Appellant's mother testified that the three respite days (including overnight) per month were necessary because both she and her husband work. The Appellant's mother testified that she works full-time as a respiratory therapist and her husband works full-time. Appellant's mother explained that the Appellant has a behavioral need for frequent redirection and respite at the level of three days/overnights per month is necessary. The Appellant's mother said that the Appellant's vocational program is three days per week through the [redacted] volunteering at [redacted]. The Appellant's mother said that on at least one day of the week the Appellant is picked up from the [redacted] and taken directly to her bowling activity.

The evidence of record demonstrates that the [redacted] PCP authorizes more than five hours of CLS services per day, including on the weekend days. In addition, the Appellant spends at least three full days in a vocational program outside the home and is involved in other community activities such as bowling and going to the library.

[redacted] testified that the Appellant's mother is paid by Medicaid to provide 11 hours a week or 1.6 hours per day of HHS personal care to the Appellant. The Medicaid Provider Manual states that Medicaid respite can not be authorized at the same time as a Medicaid-paid provider. In other words, the CMH must consider the 1.6 hours per day that Appellant's mother is paid by Medicaid for HHS personal care when it is assessing the need for respite.

The Medicaid Provider Manual reads, with regard to what Medicaid funding may be used for respite:

> **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.

> 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.
>
> *MPM, Mental Health and Substance Abuse Section, July 1, 2010, Pages 110.* (Underline added by ALJ).

In Appellant's case the evidence of record shows that the Appellant receives approximately six hours of Medicaid funded services per day. Taking into account that the Appellant lives with two parents and that the Appellant is gone from the home three days per week for vocational purposes and additional hours for other activities in the community, the CMH authorization of two days (including overnights) of respite services reasonably achieves the goal of relieving the Appellant's mother during the hours of the day she is an unpaid primary caregiver.

Authorization of services versus reduction of services

The Appellant's attorney asserted that because the [redacted] PCP authorization had less hours authorized in the [redacted] PCP, the CMH was obligated to send an advance action notice, and was required to continue services until this administrative law judge rendered a decision in the matter. Title 42 of the Code of Federal Regulations is clear that an adequate action notice is needed for authorization of services; not an advance action notice:

> **Sec. 438.404 Notice of action.**
>
> (a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
>
> (b) Content of notice. The notice must explain the following:
> (1) The action the MCO or PIHP or its contractor has taken or intends to take.
> (2) The reasons for the action.
> (3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
> (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
> (5) The procedures for exercising the rights specified in this paragraph.
> (6) The circumstances under which expedited resolution is available and how to request it.
> (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Secs. 431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1).

(4) If the MCO or PIHP extends the time frame in accordance with Sec. 438.210(d)(1), it must--

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).

Sec. 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

(a) Terminology. As used in this section, ``timely'' filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if--

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired… (Underline added by ALJ).

The evidence of record unequivocally demonstrates that the Appellant's authorization for [redacted] CMH services ended on [redacted]. The [redacted] PCP is a new authorization and therefore according to the Code of Federal Regulations an adequate action notice was the appropriate notice to be provided by the CMH. Because the Appellant's previous authorization ended on [redacted], the CMH had no obligation under the Code of Federal Regulations to continue the [redacted] level of services pending an administrative appeal. The CMH was proper to issue the notice of hearing rights attached to the PCP and to begin providing CMH services at the level authorized in the [redacted] PCP even though the [redacted] PCP authorized services at a level not agreed upon by the Appellant.

The Appellant bears the burden of proving by a preponderance of the evidence that the 36 hours per week of CLS and three day/overnight respite hours were inadequate to reasonably achieve the Appellant's goals, including CLS and rest of the goals. The testimony of the Appellant's mother did not meet the burden to establish medical necessity above and beyond the 36 hours per week of CLS and two day/overnight respite hours per month CMH assessed in accordance to the Code of Federal Regulations.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized 36 hours per week of CLS and two day/overnight respite hours per month for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 10/27/2010

***** 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.