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. 2010-46531 CMH
[redacted]

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] and continued to [redacted]. [redacted] appeared on behalf of the Appellant. [redacted] attorney, represented the Department. Her witness was [redacted]. Also in attendance was [redacted], supports coordinator.

ISSUE

Did [redacted]) properly deny the requested increase in Appellant's respite and community living supports?

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 disabled, [redacted] Medicaid beneficiary.

2. The Appellant is identified as a person with autism. Asperger's and schizophrenia are also suspected. (Department's Exhibit A, p. 22)

3. The Appellant receives the following medications; Risperdal, Focalin, XR, "Ability" [sic] Adderall XR, Strattera and Trazadone. (Department's Exhibit A, p. 1)

4. The Appellant has been serviced through [redacted] since [redacted]. He has received the following services; assessments, supports coordination, treatment planning, CLS, OT, SPL.

5. The family, in turn, has received home care training and respite.

6. The Appellant's ability to utilize verbal skills as his main form of communication has eclipsed gesturing. (Department's Exhibit A, p. 1 and *See* Testimony of [redacted])

7. The Appellant lives at home with his mother and has visitation with his father – who now lives/works out of state. (*See* Testimony and Department's Exhibit B, p. 26)

8. The Appellant's mother reports the "caretaker" has made a huge difference in her son and fostered a lot of growth. She added that there are many tasks where he achieves better results. (See Testimony of [redacted])

9. The Appellant has a PCP goal of increasing his safety skills in the community and listening to the word "stop". Staff and the Appellant's mother work to continue improvement in the Appellant's speech therapy goals – which are being met – as of [redacted]; "A little progress." (Department's Exhibit A, pp. 35-37)

10. On [redacted], the Department advised the Appellant, by adequate action notice, on the reduction of CLS and the denial of requested increase in respite. (Department's Exhibit A, pp. 1-8)

11. The Adequate Action Notice also included the Appellant's further appeal rights. (Department's Exhibit A, pp. 6-8)

12. Macomb County Community Mental Health is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

13. The Department established that the Appellant's respite services were determined to be adequate at the exisiting 10-hours per week. Department's Exhibit A – throughout.

14. The Department established that CLS could be reduced owing to the Appellant having met certain community oriented goals and because most of the remaining tasks necessary to achieve future goals can be performed by the parents of the Appellant. *See* Testimony of [redacted].

15. The Department witness added that following review of the PCP she believed that 15-hours of CLS services were adequate in amount, scope and

duration to accomplish the Appellant's goals and could be subject to change, if needed, through the PCP review process if medically necessary. *See* Testimony of Obrien.

16. The instant appeal was received by the State Office of Administrative Hearing and Rules on [redacted]. Appellant's Exhibit #1

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. Macomb County Community Mental Health 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 Medicaid Provider Manual, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[1] it states, in relevant part:

> **[CRITERIA FOR AUTHORIZING]**
>
> 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

[1] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12 – 14, [redacted]

- 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. (Emphasis supplied) MPM, Mental Health [ ] §17.2 Criteria for Authoring B3 Supports and Services, p. 98, October 1, 2010.[2]

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[RESPITE]

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid primary caregiver (e.g., family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide 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

[2] This version of the MPM is identical to the edition in place at the time of notice and appeal.

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.

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

Respite care may not be provided in:

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

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. (Emphasis supplied) MPM Mental Health [ ] §17.3.J, Respite Care Services, pp. 110, 111, October 1, 2010

Furthermore, the Medicaid Provider Manual (MPM) directs the Department and service users with the following criteria regarding CLS:

Community Living Supports (CLS)

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 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.

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(Emphasis added)

MPM, *Supra* pp. 97-101

At hearing the Department witness established that the Appellant's services as of [redacted] – were adequate in amount, scope and duration to meet his needs – including the provision of respite. Increase in respite was denied for lack of medical necessity.

She further explained that CLS was no longer required at 20 hours per week. The Appellant will now achieve targeted goals at 15 hours per week – because the remaining [CLS] necessary tasks could, in large part, be provided by the parent.

The Appellant's representative [mother] testified that the existing "caretaker" was a valuable asset in the progression of learning and social development for her son because as a "big brother" figure he was often able to communicate more effectively with the Appellant – often with better results than she could immediately reach.

The evidence showed, however, that the Appellant was progressing in meeting his communication goals and the testimony of [redacted] supported the idea that remaining educational tasks could be performed by the parent – in addition to the CLS provider.

It is important to remember that the goals delineated in the PCP are those of the individual.[3] If the Appellant is shown [in future reviews] as not meeting reasonable goals then more frequent PCP review and hours adjustment might be necessary. As of today's hearing, however, the Appellant failed to preponderate his burden of proof that

[3] See §17.1, Definitions of Goals…MPM, *Supra*

the newly established services and hours – including respite – failed to meet his needs or that additional hours of CLS were medically necessary.

This Administrative Law Judge must follow the CFR and the state Medicaid policy, and is without authority to grant respite hours out of accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR, state policy and the MPM when they authorized respite at 10-hours per week, instead of 12-hours and further when they reduced CLS from 20-hours per week to 15-hours per week for the time period following the existing authorization, ending [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized respite at 10-hours per week and properly reduced CLS to 15-hours per week.

IT IS THEREFORE ORDERED that:

The MORC decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/4/2010

***** 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.