STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-49934 CWS
Case No. 2683744

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], Appellant's [redacted], appeared on behalf of the Appellant.

[redacted] (CMH), represented the Department and Department's agent, CMH. [redacted] Michigan Department of Community Health (Department or MDCH) Children's Waivers (CWP), and [redacted] (CMH) also appeared and provided testimony.

ISSUE

Did the Department/CMH properly determine that Appellant was no longer eligible for the Children's Waiver Program and issue an advance termination notice?

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 [redacted], eligible for Medicaid via the CWP. He resides with his [redacted] in [redacted] County, Michigan.

2. The Appellant has health care services available to him through his [redacted] private health insurance.

3. [redacted] is under contract with the Michigan Department of Community Health (Department) to assess

candidates for the Children's Waiver Program (CWP) and to administer services to beneficiaries enrolled in the Children's Waiver who reside in the [redacted] service area.

4. The Appellant has medical diagnoses of cerebral palsy and seizures. (CMH Attachment D, page 32). The Appellant's diagnoses resulted in borderline intellectual functioning and a need for constant supervision. (CMH Attachment D, page 32).

5. The Appellant receives special education services at the [redacted] School.

6. The Appellant is able to perform some of his activities of daily living, with prompting and supervision.

7. The Appellant was enrolled in CMH CWP services in approximately [redacted]. (CMH Attachment C).

8. Appellant's [redacted], person-centered-plan (PCP) authorized the following CWP services: case management up to two times per month, respite up to 96 hours per month, and vacation respite up to 14 days per year. (CMH Attachment E).

9. In [redacted] the quarterly progress review indicated that the Appellant only utilized CWP respite services in the amount of 55 of the 96 hours, and in [redacted] 46.5 of the 96 hours. The review showed only one respite vacation day utilized for the quarter. (CMH Attachment F).

10. In or around [redacted], a [redacted] claims report was generated for the Appellant for the dates ranging from [redacted], through [redacted]. The claims report showed that the only CWP service used in the 18 month period was respite. (CMH Attachment F).

11. On [redacted], [redacted] sent the Appellant an advance action notice that the Appellant would be terminated from the Children's Waiver. (CMH Attachment A). The reason given in the [redacted] notice was "Consumer does not meet criteria for services requested." (CMH Attachment A). A notice indicated the effective date of termination was [redacted]. The notice to the Appellant contained information regarding a right to a fair hearing. (CMH Attachment A).

12. On [redacted], the Department received the Appellant's Request for an Administrative Hearing. (CMH Attachment A). The Appellant seeks appeal of the termination of CWP services. (CMH Attachment 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 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. The CMH in this case is [redacted].

The Department's general policy provisions for the children's waiver program are found in the Medicaid Provider Manual:

> **Section 14 - The Children's Home and Community Based Services Waiver Program (CWP)**

> The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP...
>
> The Children's Waiver is a fee-for-service program administered by the CMHSP. CMHSP is financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters…
>
> **Section 14.1 Key Provisions**
>
> The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.
>
> CMHSP is responsible for the assessment of potential waiver candidates. CMHSP is also responsible for referring potential waiver candidates to the Department by completing the CWP "pre-screen" form and sending it to the Department to determine priority rating.
>
> *Medicaid Provider Manual (MPM),*
> *Mental Health and Substance Abuse Services,*
> *p. 70.* (July 1, 2010).

The CMH representative and witnesses testified that the Appellant does not meet the CWP criterion for intensity of service and active treatment services necessary to establish an ICF/MR level of care; therefore he was no longer eligible for CWP.

Department policy lists the eligibility requirements for the CWP are as follows:

> **14.2 Eligibility**
>
> The following eligibility requirements must be met:
>
> -The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.
>
> -The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.

> -The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.
>
> -The child is at risk of being placed into an ICF/MR facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/MR facility but, with appropriate community support, could return home.
>
> -The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
>
> -The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICF/MR level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.
>
> *Medicaid Provider Manual (MPM),*
> *Mental Health and Substance Abuse Services,*
> *pp. 70-71.* (July 1, 2010).

All of the MPM Section 14.2 criteria listed above must be met in order for the Appellant to be eligible for CWP. [redacted] testified that in order for a child to be eligible for CWP he must be at risk of being placed in an ICF/MR facility because of the intensity of the child's care. [redacted] noted that in order for a child to be eligible for CWP he must also be receiving active treatment, defined as aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related service. [redacted] testified that the Department uses the definition of active treatment adopted from the Code of Federal Regulations, specifically 42 CFR 483.440. A review of 42 CFR 483.440 finds that the definition of active treatment found in the Department's CWP policy is consistent with the Code of Federal Regulations' definition.

The Appellant's [redacted] asserted that Appellant did meet the criteria to be eligible for CWP. To support this position the Appellant's [redacted] introduced five prescriptions the Appellant's physicians wrote for Appellant. The five prescriptions were written for the following: 1) blood laboratory tests; 2) psychology for socialization; 3) scoliosis

x-rays; 4) physical therapy two times per week for four weeks; 5) occupational therapy and speech therapy. (Appellant's Exhibits 1-5).

A review of the five prescriptions shows that only one of the prescriptions is for a service that is covered under the children's waiver program: psychology for socialization. (Appellant Exhibits 1-5).

Section 14.3 of the Medicaid Provider Manual lists the services covered by the CWP:

> **14.3 COVERED WAIVER SERVICES**
>
> Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:
>
> **Community Living Supports**
>
> Community Living Supports (CLS) provides assistance to a 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; 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. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.
>
> Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.
>
> The CMHSP must maintain the following documentation:
> A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.
> Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.

All service costs must be maintained in the child's file for audit purposes.

Enhanced Transportation

(definition omitted)

Environmental Accessibility Adaptations (EAAs)

(definition omitted)

Family Training (previously called Didactic Services)

This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings.

Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home. Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.

Non-Family Training (previously called Psychological/ Behavioral Treatment)

This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QMRP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

Fencing

(definition omitted)

Respite Care

Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. The maximum monthly respite allocation is 96 hours. In addition to monthly respite, vacation respite can be used up to 14 days per year and must be used in 24- hour increments.

The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) is not covered by the CWP.

When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide level respite.

Specialized Medical Equipment and Supplies

(definition omitted)

Specialty Services

Specialty Services include:
- Music Therapies;
- Recreation Therapies;
- Art Therapies; and
- Massage Therapies.

Specialty services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending

> changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid.
>
> Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month.
>
> The CMHSP must maintain a record of all Specialty Service costs for audit purposes.
>
> Hourly care services are not covered under Specialty Services.
>
> *Medicaid Provider Manual (MPM), Mental Health and Substance Abuse Services, pp. 71-78.* (July 1, 2010).

An objection to assigning controlling weight to the psychology prescription was made by the CMH because the date of the prescription for psychology was [redacted], the same date that the CMH issued its termination notice. The Appellant's exhibits one through five were made part of the record but controlling weight was not assigned because the CMH made its decision based on evidence it had gathered between [redacted] through [redacted] demonstrating the Appellant did not utilize the intensity of CWP services needed to be eligible for the CWP. The psychology prescription was not made available to the CMH in making its [redacted], termination decision. Psychology for socialization had not been utilized as an integral part of aggressive treatment for the Appellant in the prior 18 months. In addition "psychology for socialization" without any formal developed behavioral treatment plan, was viewed by the CMH as not an aggressive treatment, especially in light of the fact that the Appellant was generally a lovable child who did not exhibit significant negative behaviors or isolation.

[redacted] stated that the other four prescriptions are for services not on the list of covered CWP services. [redacted] noted that even if those services were utilized by the Appellant they would not be counted toward the "active treatment" and "intensity of services" requirements that must be met in order to be eligible for the CWP.

The Appellant's [redacted] stated that [redacted] had informed her on more than one occasion that unless the Appellant utilized more of the CWP services his eligibility for CWP most likely would be terminated. The Appellant's [redacted] explained that the reason the Appellant had not utilized more than respite services and the few art therapy sessions was due to the limitations stemming from the family's current lifestyle limitations. The Appellant's [redacted] explained that she had five children, one who is ventilator dependent and in need of her services or private duty nurse. The Appellant's [redacted] said that her [redacted] worked out of town four days a week leaving her with the total responsibility of five children, two with special needs.

Both [redacted] and [redacted] testified that it was the experience of the CWP program that most children receiving active treatment and a high intensity of services receive a moderate to high level of community living supports in order to remain in the community and not institutionalized in an ICF/MR. [redacted] stated and evidence was introduced demonstrating that the Appellant had not used any community living supports hours in the 18 months preceding the CMH termination from the CWP. Both [redacted] and [redacted] asserted that although respite was utilized, respite is intended to be primary caregiver, and for that reason is not attributed to the Appellant's use of aggressive treatment and a high intensity of services. [redacted] noted that although respite was utilized each month, less respite hours were consistently used than were authorized each month. Both [redacted] and [redacted] noted that some art therapy and the few sessions of CWP occupational therapy and speech therapy were utilized, but the mild use of these therapies fell far short of meeting the definition of need for ICF/MR services and active treatment as found in the Code of Federal Regulations.

The Code of Federal Regulations lists the eligibility criteria for admission to an ICF/MR, including the criteria for active treatment to be provided through the ICF/MR facility.

Specifically 42 CFR 440.150 provides:

> § 440.150 Intermediate care facility (ICF/MR) services.
>
> (a) "ICF/MR services" means those items and services furnished in an intermediate care facility for the mentally retarded if the following conditions are met:
> (1) The facility fully meets the requirements for a State license to provide services that are above the level of room and board;
> (2) The primary purpose of the ICF/MR is to furnish health or rehabilitative services to persons with mental retardation or persons with related conditions;
> (3) The ICF/MR meets the standards specified in subpart I of part 483 of this chapter.
> **(4) The recipient with mental retardation for whom payment is requested is receiving active treatment, as specified in § 483.440 of this chapter**. (Emphasis added by ALJ)
> (5) The ICF/MR has been certified to meet the requirements of subpart C of part 442 of this chapter, as evidenced by a valid agreement between the Medicaid agency and the facility for furnishing ICF/MR services and making payments for these services under the plan.
>
> (b) ICF/MR services may be furnished in a distinct part of a facility other than an ICF/MR if the distinct part--
> (1) Meets all requirements for an ICF/MR, as specified in subpart I of part 483 of this chapter;
> (2) Is clearly an identifiable living unit, such as an entire ward, wing,

floor or building;
(3) Consists of all beds and related services in the unit;
(4) Houses all recipients for whom payment is being made for ICF/MR services; and
(5) Is approved in writing by the survey agency.

Active treatment is defined in 42 CFR 483.440. The Department and CMH witnesses testified that the types and intensity of therapies prescribed by the Appellant's physician did or provided to Appellant not meet the active treatment requirement necessary for an ICFMR admission.

§ 483.440 Condition of participation: Active treatment services.

(a) Standard: Active treatment.
(1) Each client **must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment,** health services and related services described in this subpart, that is directed toward--
(i) The **acquisition of the behaviors necessary for the client to function with as much self determination and independence** as possible; and
(ii) The **prevention or deceleration of regression or loss of current optimal functional status**.
(2) **Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program**. (Emphasis added by ALJ)

(b) Standard: Admissions, transfers, and discharge.
(1) Clients who are admitted by the facility must be in need of and receiving active treatment services.
(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.
(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

The Appellant's [redacted] asserted that the CMH no longer has an in-home occupational therapist or speech therapist, and she had informed the CMH that it was extremely difficult for her to leave her home for several hours to bring the Appellant to occupational therapy or physical therapy at the closest location, which was more than half an hour from her home. The Appellant's [redacted] explained that while they had agreed to try community living supports services, the quality of the community living supports

workers that were coming into her home were less than desirable, were not trustworthy, and set bad examples for her children.

The CMH witness responded that while it was true that the CMH provided clinic-based occupational and speech therapy at this time, those two services are not CWP covered services. It was noted on the record at the Appellant has his [redacted] private insurance available for services that were covered by the private insurance. [redacted] further explained that CWP eligibility requires a level of care that, but for the provision of CWP services, would require the level of care provided by an ICF/MR. [redacted] argued that the CMH is obligated and held accountable for their use of CWP funds and must be able to demonstrate that the funds were used in accordance with federal law and state Medicaid policy. The [redacted] stated that based on the evidence the CMH had reviewed in Appellant's case, for at least 18 months he had not used services of the type and level needed to establish an ICF/MR level of care, and the CMH could not demonstrate to the Department or to the federal government continued eligibility for the CWP waiver.

The Appellant bears the burden of proving, by a preponderance of evidence, that he meets all of the criteria for CWP eligibility. This Administrative Law Judge commends the Appellant's [redacted] for the good care of [redacted]. However, in Appellant's case, he did not meet the burden of proving by a preponderance of evidence, that he met all of the criteria for CWP eligibility. The Appellant did not establish the active treatment or intensity of services needed to demonstrate an ICF/MR admission level of care and therefore did not establish meeting the CWP criteria.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department/CMH properly determined that Appellant was no longer eligible for the Children's Waiver Program and issued an advance termination notice.

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: 10/29/2010

***** 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.