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. 2010-51338 CMH
Case No. 28901884

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

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

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]).
2. [redacted] is under contract with the [redacted]) to provide Medicaid covered services to people who reside in the [redacted] service area.

3. The Appellant is [redacted] Medicaid beneficiary. The Appellant is diagnosed with spinal cerebral ataxia, communication disorder and severe gait/truncal ataxia. The Appellant is functionally nonverbal, has behavioral issues, and has difficulty with ambulation. (Exhibit D, page 24).

4. The Appellant lives with [redacted] and [redacted] in an apartment. (Exhibit D, page 20).

5. Appellant's [redacted] is his primary caregiver. (Exhibit D).

6. The Appellant attend school, a kindergarten class, from 7:30 a.m. to 3:30 p.m. five days a week.

7. In Appellant's [redacted] PCP the [redacted] authorized the following Medicaid services: 15 hours per week for CLS, 6.5 hours per week of respite, occupational therapy, physical therapy, and a behavioral assessment and plan. (Exhibit E).

8. On [redacted], the [redacted] performed an annual assessment, behavioral assessment, and review of the Medicaid-covered services the [redacted] authorized for Appellant in his [redacted] PCP, including documentation to support the medical need for services, as part of preparation for his [redacted] person centered plan. (Exhibit D).

9. During the review the [redacted] noted that some of the CLS goals Appellant was approved for could be accomplished in less than 15 hours a week. (Exhibits D and F).

10. During the review the [redacted] noted that some of the tasks for which Medicaid was paying for CLS were the responsibility of a parent to provide.

11. On [redacted], the [redacted] sent an Adequate Action Notice to the Appellant notifying that the 15 CLS hours per week were not supported by the documentation as medically necessary. The [redacted] mailed an Adequate Action Notice indicating the CLS hours would be authorized at 10 per week. The notice included rights to a Medicaid fair hearing. (Exhibit A).

12. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on [redacted]. (Exhibit B).

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.
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> *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. [redacted]

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.*

[redacted] witness [redacted] testified that [redacted] can only approve CLS hours for appropriate, medically necessary tasks. [redacted] witness Dr. O'Brien explained that during the development of the person centered plan the [redacted] will identify appropriate tasks and assign a reasonable time to them to develop the appropriate authorized CLS hours.

[redacted] testified that upon review of the Appellant's [redacted] person centered plan it was noted that the Appellant was approved for 15 hours of CLS in part because the Appellant was only in school part time. [redacted] asserted that at the [redacted] annual assessment it was noted that the Appellant was now attending school full-time, five days a week, from 7:30 a.m. until 3:30 p.m. and therefore was gone from the home a half day longer each day than he had when assessed for his [redacted] CLS authorization. The Appellant's mother confirmed that the Appellant is now full time in school from 7 a.m. to 3:30 p.m. [redacted] explained that with the Appellant gone from home most of each day five days a week the medical necessity of continuing 15 hours of CLS was not demonstrated.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to community living supports:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
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> 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.).
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> Coverage includes:
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> - Assisting, reminding, observing, guiding and/or training in the following activities:
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> - 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 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).

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

The [redacted] 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 that are needed to reasonably achieve his goals.

Applying the facts of this case to the documentation in the annual assessment and person centered plan supports the [redacted] position that Appellant, who is now in school full-time, had Medicaid-funded time added to his previous CLS authorization for being gone from home only for part-time school. Because the Appellant is now in full-time school he was not able to demonstrate medical necessity to approve time for tasks previously needed because he was at home more.

The Appellant's [redacted] testified that she is [redacted]. The Appellant's [redacted] stated that [redacted]. The Appellant's [redacted] stated that the Appellant's poses a great safety risk to himself due to not being aware of the safety risks around him. The Appellant's [redacted] says that she and the CLS worker constantly work with him on a daily basis to perform tasks such as picking up his clothes and putting them in his room, but the Appellant due to his ataxia, has difficulty following through on multitasking. Appellant's [redacted] stated that the reduction of five hours a week has had a significant impact on her as she not only cares for [redacted], but has mental health and physical health issues as well.

The Appellant's [redacted] testified that she must watch the Appellant at all times because he is not aware of safety risks and poses a safety risk to himself at all times.

The [redacted] representative pointed out that the Medicaid Provider Manual requires parents of children with disabilities to provide the same level of care they would provide to their children without disabilities. The [redacted] representative explained that this meant that public benefits could not be used where it was reasonable to expect the parent of a five-year-old would provide care, i.e., if the parent had to repeatedly prompt the child to perform a task, or to remind to pick up his clothes or how put on his pants, or to supervise for safety due to unstable mobility and reduced verbal skills.

With regard to the Appellant's mother's expressed concern for her own mental health and physical health the [redacted] noted that the Appellant also receives 6.5 hours respite so that [redacted] can get almost a full day's break each week or can divide the total amount of respite hours and spread them out throughout the week.

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> 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. (Underline added).
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> *MPM, Mental Health and Substance Abuse Section, July 1, 2010, Page 98*

A review of the Medicaid Provider Manual supports the [redacted] position that B3 supports and services are not intended to meet all of an individual's needs and that it is reasonable to expect that Appellant's parents would provide care for the period of time proposed by the [redacted] without use of Medicaid funding.

The Appellant bears the burden of proving by a preponderance of the evidence that the 10 hours per week of CLS was inadequate to reasonably achieve the Appellant's CLS goals. The Appellant did not meet the burden to establish medical necessity above and beyond the 10 CLS hours determined to be medically necessary by [redacted] in accordance to the Code of Federal Regulations (CFR).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly authorized Appellant's services at 10 CLS hours per week.

IT IS THEREFORE ORDERED that:

The [redacted] decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 11/8/2010

***** 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.