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

,
Appellant

______________________/

Docket No. 2010-55647 CMH (CWP)
Case No. 11140185

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 . , Appellant's , appeared on behalf of the Appellant.

(CMH), represented the Department. , appeared as a witness for the Department.

ISSUE

Did the CMH properly authorize Appellant's community living supports services at 32 hours per week (previous PCP 35 CLS hours per week).

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 (CMH). The Appellant's is enrolled in the Medicaid Children's Waiver Program.

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 Medicaid beneficiary. The Appellant is diagnosed with severe mental retardation, cerebral palsy and seizure disorder. (Exhibit F, page 1).

4. The Appellant lives with . (Exhibit F).

5. Appellant's is his primary caregiver. (Exhibit F).

6. The Appellant attends school. (Exhibit F).

7. The Appellant's 2009 through 2010 PCP the CMH authorized the following Medicaid services: 35 hours per week for CLS and 8 hours per week respite. (Exhibit H).

8. In or around , the Department of Community Health Children's Waiver Program staff CMH performed an audit review of the Medicaid-covered services the CMH authorized for Appellant in his 2009-2010 PCP, including documentation to support the medical need for services. (Exhibits C and D).

9. As a result of the Department of Community Health audit, the audit staff noted that the Appellant had significantly underutilized a number of community living supports and respite hours over the prior year. (Exhibits C and D).

10. The Department of Community Health Children's Waiver Program staff requested that the CMH contact the Appellant's and document the need to continue providing services at a level of 35 hours of community living supports and eight hours of respite per week. The Department staff requested a corrective plan of action from the CMH. (Exhibits C and D).

11. The CMH contacted the Appellant's and was informed by her that because of staffing issues it was difficult to get enough adequate staff to fulfill the 35 hours of community living supports and eight hours of respite per week. The CMH submitted a corrective plan of action to the Department. (Exhibit E).

12. On , the CMH performed an assessment for the Appellant in preparation for development of his 2010-2011 PCP. (Exhibit F).

13. Appellant's 2010 through 2011 PCP the CMH authorized the following Medicaid services: 35 hours per week for CLS and 8 hours per week respite. (Exhibit H).

14. The 2010 through 2011 PCP included an Adequate Action Notice to the Appellant notifying that 32 CLS hours per week and 8 respite hours per week were authorized. The notice included rights to a Medicaid fair hearing. (Exhibit H).

15. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on . (Exhibit 8).

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.

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.*

CMH witnesses [redacted] testified that in [redacted], the Department of Community Health Children's Waiver Program staff audited their CMH CWP cases. [redacted] testified that the Department of Community Health staff noticed that the Appellant had used only half of the authorization for community living supports in the seven months prior to [redacted]. CMH witness [redacted] added that the Department of Community Health CWP staff required that the CMH investigate why only half of the authorized community living supports hours were utilized in 2009-2010 and to report back to the Department to determine whether the CMH was out of compliance with the children's waiver program requirements. [redacted] and [redacted] said they did further investigate, including obtaining the billings for the Appellant for least one year worth of time and noted that in fact the Appellant had not utilized a substantial portion the CLS authorization. (Exhibit G). [redacted] testified that she spoke with the Appellant's [redacted], and asked [redacted] to discuss with the Appellant's [redacted] the drastic reduction in use of CLS hours from what was authorized.

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**
>
> 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 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.

CMH witness [redacted] testified that she spoke with Appellant's [redacted] and Appellant's [redacted] described the incidences that were occurring with regard to CLS workers; Appellant's [redacted] was having a difficult time retaining regular community living supports workers because of personal problems each of the CLS workers were having. Appellant's [redacted] explained to [redacted] that an additional reason for not using all the community living supports hours was that the Appellant was going to school for more hours during the week than he had in 2008.

The Appellant's [redacted] testified it was not explained to her that if community living supports hours were not used as authorized it could put the hourly authorization into jeopardy. The Appellant's [redacted] explained that she felt that the reduction of three hours per week happened without her being able to contribute input into what had been occurring to result in the drastic reduction in use of CLS hours.

Department Medicaid policy incorporates and elaborates on the federal regulation requirement that Medicaid-funded services only be provided in an appropriate amount. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

2.5.B. MEDICAL NECESSITY DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2010, page 13.

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 Medicaid medically necessary services that are needed to reasonably achieve his goals. *See again 42 CFR 440.230.* Federal regulation also requires that accountability measures be in place and implemented. In other words, the state of Michigan must be able to demonstrate that it is implementing the program based on appropriate amount, scope, and duration. What this means for Appellant's case is that Appellant, in order to demonstrate the appropriate amount, scope, and duration has been authorized, must present documentation that he is using the amount, scope, and duration of services for which he is authorized. The weight of the evidence

establishes that he was not using a substantial quantity of the amount, scope and duration of services for which he was authorized.

The Appellant's testified that the full 35 hours of CLS are needed because emergencies regularly occur. The Appellant's explained that while it is fine to have a situation where a plan of addendum can be put in place to increase services to cover instances such as when she and her went to their high school reunion, other increases in need occur with only minimal notice. Appellant's provided the example of how she received a call on the weekend that her was having chest pains and had to take him to a hospital in Kalamazoo. She also provided the in an example of how recently her was stung by a bee at school and she had to immediately leave to go to school to attend to her .

This Administrative Law Judge listened to and understands the Appellant's challenges in obtaining and retaining community living supports providers that are reliable. However, the reduction in services was not entirely due to a short-term unforeseeable circumstance with the CLS worker, rather the undisputed credible evidence in this case shows that less than half the CLS hours authorized were utilized over one years worth of time.

In addition, the CMH elaborated and provided document evidence of the process and means by which it assesses the Appellant's strength and needs. (Exhibit F and P). The CMH evidence established that it provided a proper assessment of the Appellant's needs for his 2010-2011 person center plan.

To address the Appellant's concern that there was no advance action notice of the three hour CLS difference from the prior PCP to the 2010-2011 PCP, a review of the credible evidence of record demonstrates that the Appellant's 2009-2010 person centered plan authorization ended on . The CMH was not required to send an advance action notice because on , there was a natural end to the previous year's authorization. It was proper for the CMH to include in its 2010-2011 PCP authorization notice of a right to fair hearing if the Appellant was not satisfied with the authorization period.

The Appellant bears the burden of proving by a preponderance of the evidence that the 32 hours per week of CLS was inadequate to reasonably achieve the Appellant's CLS goals, including demonstrating that the Appellant made regular use of his CLS authorization. The Appellant did not meet the burden to establish that 35 CLS hours are medically necessary and are an appropriate amount in accordance to the Code of Federal Regulations (CFR) or the Department Medicaid policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized Appellant's services community living supports at 32 hours per week (previous PCP 35 CLS hours per week).

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:

Date Mailed: 11/12/2010

***** 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 35 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 35 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 35 days of the receipt of the rehearing decision.