STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-46090 CMH
Case No. 10147422

Appellant
_____/

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

[redacted], Due Process Hearings Coordinator, appeared on behalf of [redacted] County Community Mental Health. [redacted], Utilization Management Coordinator and [redacted], Utilization Care Coordinator, appeared as witnesses for the Department.

ISSUE

Did the CMH properly reduce the Appellant's community living supports and respite?

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 who has been receiving services through [redacted] County Community Mental Health (CMH) since [redacted]. (Exhibit A)

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 an [redacted] year old Medicaid beneficiary whose date of birth is

[redacted]. The Appellant is diagnosed with autism and severe mental retardation. (Exhibit A, p 43).

4. The Appellant lives with her parents, a sibling, and her paternal grandmother. (Exhibit A, page 47).

5. Appellant's mother is her primary caregiver. Appellant's father is bedridden with congestive heart failure and is unable to provide any assistance in the care for Appellant. Likewise, Appellant's paternal grandmother is unable to care for her own needs, so is unable to assist in Appellant's care. (Exhibit A, page 47).

6. Appellant is in special education at [redacted] Center. (Exhibit A, p 48).

7. In [redacted], Appellant's mother requested 34.5 hours per week of Community Living Supports (CLS). On [redacted] an Individual Plan of Service Meeting was held, at which it was determined that Appellant was only eligible to receive 6 hours per week of CLS. (Exhibit A, pp 1-21). Upon review by [redacted], Utilization Management Coordinator, the amount of CLS hours was increased to 8.5 hours per week. (Testimony)

8. On [redacted], the Department conducted a Respite Assessment. As a result of the Assessment, Appellant's respite hours were reduced from 96 hours per month to 54 hours per month. (Exhibit A, pp 25-29)

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying her that her respite hours were being reduced from 96 hours per month to 54 hours per month. The notice included rights to a Medicaid fair hearing. (Exhibit A, pp 30-31).

10. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying her that her request for 34.5 hours per week of CLS was denied and that 6 hours per week of CLS were approved. (This was later increased to 8.5 hours of CLS per month). The notice included rights to a Medicaid fair hearing. (Exhibit A, pp 22-23).

11. The Michigan Administrative Hearing System received Appellant's request for hearing regarding the reduction in respite hours on [redacted] and the request for hearing regarding the CLS hours on [redacted]. (Exhibits B & C).

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. 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 witness [redacted], Utilization Management Coordinator, reviewed Appellant's Individual Plan of Service and testified that Appellant was granted 3 CLS hours per week to help with her sensory activities, 3 CLS hours per week for her OT, and an additional 2.5 CLS hours per week for her brushing/joint compression activities and her wrap and rock activity. (Exhibit A, pp 17-18). [redacted] testified that Appellant was not eligible for any CLS hours for the other goals in her PCP and that the CLS hours granted were sufficient in duration, scope and intensity to meet Appellant's goals.

[redacted], Utilization Care Coordinator, testified that she completed a Respite Assessment for Appellant on [redacted]. [redacted] testified that Appellant was awarded 4 respite hours because one of Appellant's care givers does not work and is not a student, 4 respite hours because the primary care giver has a health condition that prevents the provision of care, 2 respite hours because Appellant required 1-2 interventions per night, 2 respite hours because Appellant is physically abusive to others on a weekly basis, 3 respite hours because Appellant is abusive towards herself on a daily basis, and 1 respite hour because Appellant has daily temper tantrums. [redacted] testified that Appellant was also awarded 4 respite hours because she requires total physical assistance with oral care, 3 respite hours because Appellant can eat independently after set up, 4 respite hours because Appellant requires total physical assistance with bathing, 4 respite hours because Appellant requires total physical assistance with toileting, and 4 respite hours because Appellant requires total physical assistance with dressing. Finally, [redacted] testified that Appellant was granted 4 respite hours because she needs total physical assistance with grooming, 2 respite hours because Appellant is non-verbal, and 3 respite hours because Appellant requires extensive prompting and encouragement to participate in tasks.

Ms. Merciez explained that Appellant's overall number of respite hours is lower than it used to be because the scoring tool changed in May 2011. Under the prior scoring tool, individuals were granted 20 hours respite from the start, then additional hours were added depending on specific needs. Under the current scoring tool, individuals are no longer granted 20 hours respite up front and, according to Ms. Merciez, the overall tool is much more objective and needs based.

The Appellant's mother testified that Appellant needs to have a daily routine and that she needs to be constantly doing something, or she gets frustrated. Appellant's mother indicated that 8.5 CLS hours per week were simply not enough. Appellant's mother indicated that her husband is bedridden and unable to provide anything but moral support to Appellant and that her grandmother is likewise unable to provide any support because she is illiterate and retarded herself. With regard to respite, Appellant's mother testified that she had always received at least 86 respite hours per month and she did

not understand how the hours could be reduced given that Appellant's condition had not improved, but had actually gotten worse.

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

> **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.).
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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, 2011, Page 100.

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 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 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.
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> *July 1, 2011, Page 110.*

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 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 assessment and person centered plan supports the CMH position that the goals in Appellant's PCP can be accomplished in the 8.5 hours per week of CLS authorized and that the Appellant's mother's respite needs could be met with the 54 respite hours per month authorized.

The CMH representative further 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 CMH representative explained that this meant that public benefits could not be used where it was reasonable to expect the parent would provide care, i.e., if the parent had to purée or cut food into very small pieces to prevent choking, or supervise for safety due to lack of mobility and verbal skills.

The CMH witnesses noted that the total amount of proposed CMH services, combining respite and CLS, were an adequate number of hours to reasonably achieve the Appellant's CLS goals and Appellant's mother's respite goals.

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. (Emphasis added).
> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 98*

A review of the Medicaid Provider Manual supports the CMH 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 mother would provide care for the period of time proposed by the CMH without use of Medicaid funding.

The Appellant bears the burden of proving by a preponderance of the evidence that the 8.5 hours per week of CLS was inadequate to reasonably achieve the Appellant's CLS goals, and that 54 hours of respite per month was inadequate to meet the Appellant's parent's goals. The testimony of the Appellant's mother did not meet the burden to establish medical necessity above and beyond the 8.5 CLS hours per week and the 54 respite hours per month determined to be medically necessary by CMH 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 CMH properly approved 8.5 CLS hours per week for Appellant and 54 respite hours per month for Appellant's mother.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

[redacted]
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **9/15/2011**

***** 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.