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. 2011-50118 CMH
Case No. 54740708

Appellant
_____/

AMENDED 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 brother, and [redacted], Appellant's mother/guardian, appeared on behalf of the Appellant.

[redacted], Due Process Hearings Coordinator, appeared on behalf of [redacted] County Community Mental Health (CMH or Department). [redacted], Director of Care Management and [redacted], Supports 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). (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 a [redacted] year old Medicaid beneficiary whose date of birth is

[redacted]. (Exhibit B, p 3) The Appellant is diagnosed with Severe Mental Retardation with Non-Spastic Cerebral Palsy and Epilepsy. (Exhibit B, p 6). Appellant's seizure disorder has been stable without incident for the past four years. (Exhibit A, p 1)

4. The Appellant lives at home with his parents and siblings. Appellant's parents are his guardian and payee. Appellant's overall functioning is very limited and contingent on 24 hour care. (Exhibit A, page 1; Exhibit B).

5. Appellant's last Person Centered Plan (PCP) was conducted in May 2011. At that time, Appellant was approved for 16 hours of CLS per week and 30 hours of respite per month. (Exhibit B, p 21). Appellant also receives 2 hours per day of Adult Home Help from the Department of Human Services for which his mother is the paid provider and he attends the [redacted] A Skill Building program at [redacted] four days per week. (Exhibit A, p 1)

6. In [redacted], CMH conducted a review of all persons receiving services through the Department. Following the review, CMH reduced Appellant's CLS hours from 16 hours per week to 10 hours per week and terminated Appellant's respite hours because it determined they were no longer medically necessary because respite is provided only to unpaid caregivers and Appellant's mother is a paid caregiver. (Exhibit B, pp 1-2)

7. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying him that his respite hours were being terminated and that his CLS hours were being reduced from 16 hours per week to 10 hours per week. The notice included rights to a Medicaid fair hearing. (Exhibit B, pp 1-2).

8. The Michigan Administrative Hearing System received Appellant's Request for Hearing on or about [redacted]. (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 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.*

[redacted], Director of Care Management testified that Appellant's services were reviewed as part of an Agency wide review of all Medicaid recipients precipitated by

yearly budget considerations. Upon review of Appellant's services, it was determined that 10 hours per week of CLS would be sufficient to meet Appellant's goals, especially given that Appellant's twin brother also receives 10 hours per week of CLS, for a total of 20 hours of CLS per week in the home. [redacted] testified that Appellant's respite hours were terminated because respite is designed to relieve unpaid caregivers and here Appellant's mother is a paid caregiver. [redacted] also testified that respite can be made available to Appellant's mother upon request and as needed to relieve her if the circumstances so require.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to B3 supports and services, community living supports and respite:

> **17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES**
> 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
> - 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 added)

MPM, Mental Health and Substance Abuse Section, October 1, 2011, Page 105.

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, October 1, 2011, Pages 107-108.*

> **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.
>
> *October 1, 2011, Page 118.*

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 his goals. The CMH must also take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. In the present case, all Medicaid beneficiaries covered by this CMH were subjected to a review of services due to a budgetary shortfall and, while services may not be reduced or terminated solely because of budgetary reasons, an individual review of Appellant's services did reveal that a reduction in services was necessary.

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 10 hours per week of CLS authorized.

The CMH witness noted that the total amount of proposed CMH services, combining CLS, Skill Building, Chore Help, and Adult Home Help, were an adequate number of hours to reasonably achieve the Appellant's CLS goals.

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 reduction in CLS hours is also reasonable given that Appellant's twin brother will also be receiving 10 hours per week of CLS; making the total for the household 20 hours per week.

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 testimony of the Appellant's brother and mother did not meet the burden to establish medical necessity above and beyond the 10 CLS hours per week 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 10 CLS hours per week for Appellant and properly terminated Appellant's monthly respite hours given that Appellant's mother is a paid caregiver.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: ____**11/2/2011**_____

***** 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.