**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 2012-34468 CMH

[redacted],

[redacted]

Appellant

_____/

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. At that time, Appellant's hearing was consolidated with a hearing involving her brother [redacted].[1]

[redacted], Appellant's mother and legal guardian, appeared and testified on behalf of Appellant and her brother. [redacted], care manager, [redacted], supports coordinator, and [redacted], registered nurse, also testified as witnesses for Appellant.

[redacted], Fair Hearings Officer, represented Lifeways Community Mental Health (CMH). [redacted], Director of Utilization Management, appeared as a witness for Respondent.

## ISSUE

Did the CMH properly terminate Appellant's Community Living Supports (CLS)?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old woman who has been diagnosed with profound mental retardation, cerebral palsy, chronic obstructive pulmonary disease (COPD), tracheotomy, hydrocephallic, a need for a G-tube, blindness, and no functional use of her arms and legs. (Exhibit 3, pages 13, 30).

2. Appellant lives with both her mother/legal guardian and her brother James Kinstle. (Exhibit 3, page 14; Exhibit 4, page 3).

[1] Docket No. 2012-34466 CMH; Case No. 38946938.

3. The 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.

4. Together with her brother, Appellant had been receiving services through the CMH, including [redacted] hours of private duty nursing (PDN) and eight hours of CLS per day. Both the nurse and the aide were working on a 2:1 basis and were providing services to both Appellant and her brother. (Exhibit 3, page 14; Testimony of [redacted]; Testimony of [redacted].

5. The private duty nurse and CLS aide would be present for the same 8 hour period and Appellant's mother would take care of Appellant and her brother during the remaining [redacted] hours of the day. (Testimony of Morris).

6. On [redacted], Appellant's mother informed the CMH that she would be undergoing knee surgery on [redacted] and would be unable to provide care for her children between [redacted] and [redacted]. (Exhibit 3, page 6). Appellant's mother also requested that the CMH provide [redacted] hours a day of care during that period. (Testimony of Clevenger).

7. In response to Appellant's request, the CMH approved [redacted] hours a day of PDN for four weeks at a rate of 1 nurse for two individuals. However, the CMH also found that any services provided by the CLS aide would be duplicative of the private duty nurse's services. (Exhibit 3, pages 7-8; Testimony of [redacted].

8. On [redacted], the CMH notified Appellant that the [redacted] hours a day PDN was approved for the time period of [redacted] through [redacted] at a 2:1 rate, but that her CLS would be terminated as of February 13, 2012. (Exhibit 3, page 9).

9. On [redacted] the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing. In that request, Appellant argues that the services of both a nurse and a CLS aide are medically necessary during the day. (Exhibit 4, pages 1-2).

10. Given the timely filed appeal, the CMH has been providing both [redacted] hours of PDN and [redacted] hours of CLS per day while this appeal is pending. ([redacted]).

11. The [redacted] hours of PDN per day was also reauthorized through the end of [redacted] (Testimony of [redacted]).

## 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…
>
> (42 USC 1396n(b))

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.

Here, the issue in this case involves what services must be provided. Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

As a preliminary matter, this Administrative Law Judge would note that the dispute in this case may be moot. As discussed above, Appellant wanted 24 hours of PDN and 8 hours of CLS per day while her mother was recovering from knee surgery. The CMH authorized 24 hours of PDN per day through the end of March of 2012, but wants to terminate CLS. However, the CMH also continued to provide CLS while this appeal was pending. During the hearing, Appellant's mother testified that she could resume taking care of her children during the night after April 1, 2012, which has now passed.

Nevertheless, it is unclear whether the CMH would allow Appellant and her family to return to its previous arrangement of having both the nurse and the CLS aide work during the same 8 hour period. Appellant argues that such an arrangement is medically necessary while the CMH appears to argue that it would be a duplication of services.

With respect to medical necessity, the Medicaid Provider Manual (MPM) provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or

- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

**2.5.B. 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.

(MPM, Mental Health and Substance Abuse Section, January 1, 2012, pages 12-13)

Here, it is undisputed that the arrangement for years has involved both a private duty nurse and a CLS aide for [redacted] hours a day. Appellant's witnesses also testified that, for the entire time she has been receiving services, the nurse and the aide have been there for the same [redacted] hour period per day. (Testimony o[redacted]; Testimony of [redacted]. According to Appellant's witnesses, that period is when Appellant and her brother need the most assistance. (Testimony of [redacted]; Testimony of [redacted]. Appellant's mother would then watch them for the remaining [redacted] hours of the day, when they were in bed/sleeping and required less assistance. (Testimony of [redacted]; Testimony of [redacted]).

The CMH's witness, on the other hand, testified that the CMH did not know that the services were being utilized at the same time and, after [redacted] hours a day of private duty nursing was approved, she was told to terminate the CLS because it was a duplication of services. (Testimony of [redacted]

As noted by the CMH, there is a policy against a duplication of services. However, it is not clear that services are being duplicated in this case and the CMH failed to provide any evidence in support of that assertion. The CMH's sole witness was [redacted] and she merely testified that she was told policy dictated the termination of CLS. (Testimony of [redacted]. She could not testify regarding the basis for the determination that services would be duplicated if the nurse and the aide were present at the same time. (Testimony of [redacted] Similarly, she could not testify regarding what was medically necessary and she did not disagree with the testimony of Appellant's witnesses. (Testimony o[redacted]).

Appellant's witnesses specifically testified regarding a medical need for there to be both a nurse and a CLS aide present during the day. As testified to by [redacted] the CLS aide does assist the nurse, but they have different duties and there are tasks that only a nurse can do. (Testimony o[redacted]; Exhibit 14). [redacted] also testified that neither an aide nor a nurse can be there alone during the day because of the significant medical needs of Appellant and her brother. (Testimony of [redacted]. In particular, [redacted] testified that it takes two people to transfer either Appellant or her brother. (Testimony of [redacted]). Other documents submitted by Appellant also assert that it takes two people to transfer either Appellant or her brother. (Exhibit 5; Exhibit 7; Exhibit 16). Also, it is beneficial to have two people there providing care because Appellant and her brother both have needs, often at the same time. (Testimony of Butler).

Given the above testimony and the past history of the use of services in this case, this Administrative Law Judge finds that Appellant has met her burden of demonstrating by a preponderance of the evidence that the CMH erred by terminating her CLS. All of the

evidence in the record suggests that it is medically necessary for there to be two workers, including a nurse, present during the day for Appellant and her brother. There is absolutely no evidence or testimony that there is a duplication of services. Accordingly, the CMH's decision must be reversed.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly terminated Appellant's CLS.

**IT IS THEREFORE ORDERED** that:

The CMH's decision is REVERSED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-4-12

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.