

**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) 373-4147

IN THE MATTER OF:

Docket No. 2013-69745 CMH

██████████

██████████

██████████

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 the request for a hearing filed on behalf of the minor Appellant/Petitioner.

After due notice, a hearing was held on ██████████ Appellant's mother, appeared and testified on his behalf. ██████████ attorney and Due Process Hearings Coordinator, represented Respondent ██████████ (the "CMH"). ██████████ social worker and supervisor of children and family services, and ██████████, registered nurse and compliance coordinator, from the ██████████) testified as witnesses for Respondent.

ISSUE

Did the CMH properly deny Appellant's request for a combined ██████ hours of Community Living Supports (CLS) and respite care services per week and, instead, only authorize ██████ hours a week of 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. The CMH is under contract with the Department of Community Health (MDCH) to provide specified Medicaid covered services to people who reside in the CMH's service area.

¹ This matter was originally docketed with ██████████ the minor Appellant's mother, as the named appellant. However, it is clear from the record that the named appellant should be ██████████ as it is his services at issue and the request for hearing was filed on his behalf. Accordingly, the matter has been re-titled. The parties were always aware of the nature of the appeal and are not prejudiced by the change.

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2. In turn, the CMH contracts with service providers such as ██████████ to provide Medicaid covered services.
3. Appellant is a ██████ year-old male who has been diagnosed with Autistic Disorder. (Respondent's Exhibit A, pages 1-2; Respondent's Exhibit B, page 2).
4. Appellant and his mother/representative previously lived in ██████████ and were receiving a combined ██████████ hours of services per week of CLS and respite care services through ██████████. (Respondent's Exhibit B, page 2; Testimony of Appellant's representative).
5. On ██████████, Appellant's representative held an intake meeting with the CMH. At that time, she and Appellant were in the process of moving to ██████████. (Respondent's Exhibit B, page 2).
6. During that meeting, Appellant's representative requested that Appellant receive the same amount of services through the CMH that he had been receiving in ██████████. (Respondent's Exhibit B, page 2).
7. The parties also developed a Person Centered Plan (PCP) for Appellant for the period of ██████████ through ██████████ (Respondent's Exhibit B, pages 1-10).
8. According to Appellant's representative, she was also told at that time that Appellant would only be approved for ██████████ hours of CLS per week. (Testimony of Appellant's representative).
9. On ██████████, Appellant's representative and the CMH held another meeting regarding Appellant's Individual Plan of Service (IPOS). (Respondent's Exhibit A, page 2).
10. During that meeting, it was noted that Appellant's representative and her ex-husband had a parenting agreement stating that Appellant would stay with the ex-husband ██████ day each week and ██████████-weekend. (Respondent's Exhibit A, page 2).
11. An IPOS for the time period of ██████████ through ██████████ was developed after that meeting. (Respondent's Exhibit A, pages 1-16).
12. Per that IPOS, Appellant was approved for ██████ hours of CLS per week. (Respondent's Exhibit A, pages 6, 9).

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13. However, according to Appellant's representative, she was told that Appellant was approved for ██████████ hours of CLS per week. (Testimony of Appellant's representative).
14. In any event, the IPOS also notified Appellant's representative of Appellant's appeal rights and Appellant's representative subsequently filed a request for hearing on Appellant's behalf regarding the amount of services approved. (Respondent's Exhibit A, pages 15-16; Petitioner's Exhibit 1, pages 1-3).
15. The request for hearing was received by the Michigan Administrative Hearing System (MAHS) on ██████████ (Petitioner's Exhibit 1, pages 1-3).
16. In that request for hearing, Appellant's representative stated that she was appealing the authorization of 5 hours per week of CLS and no respite care services. The request also stated that the CMH should provide the full ██████████) hours per week of services it grants other families and that Appellant needs around-the-clock care. The request further stated that Appellant's representative was having a difficult time hiring workers given the small amount of hours approved. (Petitioner's Exhibit 1, pages 1-3).
17. On ██████████, a Periodic Review was held with respect to Appellant's IPOS. (Respondent's Exhibit D, pages 1-3).
18. According to the CMH's documentation and witnesses, one of Appellant's goals was amended during that review to include assistance with showing skills and his CLS was therefore increased to ██████████ hours per week. (Respondent's Exhibit D, page 1; Testimony of ██████████).
19. According to Appellant's representative, she was never informed about any increase in CLS. (Testimony of Appellant's representative).
20. One of the CMH's witnesses also testified that, prior to the hearing in this matter, the CMH and MORC reviewed Appellant's case and determined that Appellant's CLS should be increased to ██████████ hours per week. The effective date of the increase was to be ██████████. (Testimony of ██████████).
21. According to Appellant's representative, she was never informed about any increase in CLS and only learned of it through the hearing summary she received from the CMH for the hearing. (Testimony of Appellant's representative).
22. A hearing in this matter was held on ██████████

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

Moreover, 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)

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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.

The CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department. In turn, the CMH contracts with service providers such as MORC to provide specific Medicaid covered services.

Among the services that can be provided by the CMH and MORC are Community Living Supports (CLS) and respite care services.

With respect to CLS, the applicable version of the Medicaid Provider Manual (MPM) provides:

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 (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
 - > meal preparation
 - > laundry
 - > routine, seasonal, and heavy household care and maintenance

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- > 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 appears to be needed, the beneficiary 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. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the 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)

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- > 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 non-medical 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 coverage Personal Care in Specialized Residential Settings. 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.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

*MPM, April 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 114-115*

Moreover, with respect to respite care services, the MPM also provides:

17.3.J. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid 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.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is

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receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MRs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served

- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

MPM, April 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 125-127

However, while CLS and respite are Medicaid-covered services, Medicaid beneficiaries are only entitled to medically necessary covered services for which they are eligible and 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.

With respect to medical necessity, the MPM, April 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 12-13, 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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;

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- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS and respite care services:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and

services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

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.

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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.

MPM, April 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 111-112

Here, it is undisputed that Appellant needs some services and it is only the amount of hours to be authorized that is at issue. As discussed above, Appellant requested █████ hours per week of combined CLS and respite care services initially and continued to request at least █████ hours per week of such services in the request for hearing. The CMH only approved █████ hours of CLS per week at first, before subsequently increasing the authorization of CLS to █████ hours per week and then to █████ hours per week. Appellant's representative credibly testified that she was never informed of the later increases, but the CMH's representative identified the increases on the record at the hearing; the CMH will be held to those increases; and it is the final authorization of █████ hours per week of CLS that will be considered in this case.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for respite care services or additional CLS hours. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

As a preliminary matter, this Administrative Law Judge would note that, while Appellant was seeking █████ hours of services in whatever combination of CLS and respite care services the CMH was willing to authorize, the provisions of the MPM quoted above clearly provide that those two types of services are distinct and serve different purposes. For example, CLS "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" while respite care services "are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they

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are providing unpaid care.” (MPM, April 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 114, 125).

Moreover, taking into account that definition of respite care services and the rest of the record in this case, this Administrative Law Judge finds that Appellant failed to meet his burden of proving that the CMH erred in denying the request for respite care services. Appellant’s representative/mother is a single mother taking care of Appellant most of the time, but she also has a parenting agreement stating that her ex-husband would care for Appellant ██████ day each week and ██████ r-weekend. Additionally, Appellant also attends school and is approved for ██████ hours of CLS per week. Given those other supports, it does not appear that Appellant’s primary caregiver would require any short-term, intermittent relief from the daily stress of caring for Appellant.

With respect to the authorization of CLS, this Administrative Law Judge finds that Appellant also failed to meet his burden of proving that the CMH erred. Here, Appellant’s representative appears to be seeking services, in whatever form, as general child care. However, CLS is not meant to provide such general care. Instead, CLS are only to be used “to increase or maintain personal self-sufficiency, facilitating an individual’s achievement of his goals of community inclusion and participation, independence or productivity.” (MPM, April 1, 2013 version, Mental Health/Substance Abuse Chapter, page 114). Similarly, B3 supports and services in general are only intended to “to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.” (MPM, April 1, 2013 version, Mental Health/Substance Abuse Chapter, page 110).

Appellant’s plan does contain general, but appropriate goals regarding CLS, including supporting the family’s ability to respond to Appellant’s needs; keeping Appellant safe in the community; and increasing Appellant’s independence. (Respondent’s Exhibit A, pages 4, 7-8). However, ██████ hours of CLS per week appears more than sufficient to meet those goals and Appellant’s representative did not identify specific aspect of those goals that Appellant needs more time for.

Appellant’s representative further testified that she has had difficulties hiring CLS workers given the amount of hours approved. However, while this Administrative Law Judge appreciates the problems Appellant’s family is having, those issues are beyond the scope of the hearing and the CMH’s witnesses also testified that they will continue to work with Appellant’s representative in finding workers. Nevertheless, it is also worth noting that Appellant’s services have only been in place for a short time and, given the difficulties in hiring staff, it is impossible to find at this point that the amount, scope and duration of the approved services is insufficient. To the extent Appellant’s representative finds that the ██████ hours of CLS per week is not enough once the services are in place, she can always request additional services in the future.

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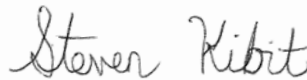
As discussed above, Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for respite care services or additional CLS hours. Here, however, Appellant failed to meet that burden of proof. The CMH authorized a sufficient amount of CLS to meet the goals of Appellant's plan while also properly denying respite care services given the circumstances surrounding Appellant's care.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request for a combined [REDACTED] hours of CLS and respite services per week and, instead, only authorized [REDACTED] hours a week of CLS.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.



Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

***** 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.