

**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) 334-4147

IN THE MATTER OF:

██████████
Appellant

Docket No. 14-010569 CMH
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████, Appellant's mother, appeared and testified on Appellant's behalf. ██████████ appeared as an interpreter. Appellant's witnesses were ██████████, Behaviorist and ██████████, Supports Coordinator.

██████████, Assistant Corporation Counsel, ██████████ County Community Mental Health Authority (CMH), represented the Department. ██████████, ██████████ Supervisor, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request for increased Community Living Supports (CLS) and respite services?

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 ██████ year old Medicaid beneficiary, born ██████████, receiving services through Macomb County Community Mental Health (CMH). (Exhibit A, p 16; Testimony)
1. 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. (Testimony)
2. Appellant is diagnosed with autistic disorder and severe mental retardation. (Exhibit A, p 36; Testimony)

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3. Appellant is functionally non-verbal and is unable to answer simple questions or relate personal experiences. Appellant has substantial functional limitations in the areas of self-care, receptive and expressive language, learning and self-direction. (Exhibit A, p 24; Testimony)
4. Appellant lives in a private home with his biological parents and three minor siblings. Appellant's youngest sibling was born on ██████████. Appellant has minimal other natural supports. (Exhibit A, pp 24-25; Testimony)
5. Appellant attends ██████████ in the Autistic Impaired special education program. (Exhibit A, p 25; Testimony)
6. Appellant receives CLS, respite, behavioral services, psychiatric services, and supports coordination through CMH. (Exhibit A, p 25; Testimony)
7. Appellant needs complete assistance/hands on support in completing all activities of daily living. Appellant's three younger siblings also require full time care. (Exhibit A, p 25; Testimony)
8. In ██████████, a request was made on Appellant's behalf for 21 hours of CLS per week and 80 hours of respite per month. After reviewing Appellant's Annual Assessment, Person Centered Plan, and electronic medical records, the CMH approved Appellant for 15 hours of CLS per week and 50 hours of CLS per month. (Exhibit A, pp 16-60; Testimony)
9. On ██████████, Appellant was notified that he was approved for 15 hours of CLS per week and 50 hours of respite per month. With regard to CLS, the notice indicated: "Intensity of service authorized is sufficient in amount, scope, and duration to reasonably meet the objectives within the Periodic Review and address the goals of promoting community inclusion and participation, independence and / or productivity in conjunction with other services authorized." With regard to respite, the notice indicated: "Because Clt will be returning to school which provides the care gives a break and the intensity of respite services authorized are adequate in intensity to assist in maintaining the goal of living in a natural community home by temporarily relieving the unpaid caregivers from caregiving." (Exhibit A, pp 8-10; Testimony)
10. Appellant's request for a hearing was received by the Michigan Administrative Hearing System on ██████████. (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).

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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

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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*.

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.

The *Medicaid Provider Manual, Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan. It states, in relevant part:

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

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
 - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - that are experimental or investigational in nature; or
 - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

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.

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, (revised 7/1/2011), observing, guiding and/or training in the following activities:
 - meal preparation

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- 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.

17.3.I. 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 receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is

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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
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IID's, 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

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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.

Medicaid Provider Manual
Mental Health and Substance Abuse Section
July 1, 2014, pp 12-14, 111-112, 124-126

CMH's [REDACTED] Supervisor testified that one of the functions of the [REDACTED] is to determine the amount, scope and duration of services for clients approved for services through CMH. CMH's [REDACTED] Supervisor indicated that Appellant is [REDACTED] years old and is diagnosed with autistic disorder and severe mental retardation. CMH's [REDACTED] Supervisor testified that Appellant receives CLS, respite, behavioral services, psychiatric services, and supports coordinator through CMH. CMH's [REDACTED] Supervisor testified that in reviewing Appellant's file and medical records, she concurred that the amount of CLS authorized was sufficient to meet Appellant's goals and needs. CMH's [REDACTED] Supervisor indicated that in making this determination, she reviewed the goals in Appellant's Person Centered Plan (PCP) and agreed that the amount of CLS authorized was sufficient to meet those goals.

With regard to respite, CMH's [REDACTED] Supervisor testified that respite is designed to give primary caregivers short-term, intermittent breaks in the care of the beneficiary. CMH's [REDACTED] Supervisor testified that for someone with Appellant's needs, CMH normally authorizes 12.5 hours of respite per week, or 50 hours per month. CMH's [REDACTED] Supervisor indicated that there was nothing in Appellant's records indicating that he needed more than this amount of respite. CMH's [REDACTED] Supervisor also testified that she considered the cumulative services that Appellant receives during the week when making the determination, as allowed by policy. The CMH also pointed out in its hearing summary that Appellant is now back in school, so that gives the family a daily break from his care needs.

Appellant's behaviorist testified that he has been working with Appellant since [REDACTED]. Appellant's behaviorist indicated that his main concern with the amount of services authorized is that since Appellant's youngest sibling was born in [REDACTED], Appellant has become agitated and aggressive towards the infant. Appellant's behaviorist testified that the current plan he is working on with Appellant and his family requires Appellant to take up to 5 breaks per day (when the infant cries, causing Appellant to become agitated and aggressive), and that there will not be sufficient staff to make this happen. (See Behavior Plan, Exhibit 2). Appellant's behaviorist testified that if staff is not in the home when the breaks are needed, the practicing and the plan will not be effective. Appellant's behaviorist did indicate that a family member could be trained to handle the breaks, however.

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Appellant's supports coordinator testified that she has worked with Appellant for almost three years. Appellant's supports coordinator indicated that since Appellant's youngest sibling was born in ██████████, Appellant's doctor has noted homicidal tendencies in Appellant. (See Medication Review Notes, Exhibit 2). Appellant's supports coordinator testified that Appellant acts out towards the baby, and his other siblings on a daily basis. Appellant's supports coordinator testified that she asked for the increase in CLS and respite because Appellant is not capable of being integrated into the community unless both his mother and staff are present. Appellant's supports coordinator testified that Appellant has a history of attempted elopement, especially from the family vehicle or the school bus. Appellant's supports coordinator indicated that Appellant does use a restraint vest, but he still removes his shoes and throws them at the bus driver or others. Appellant's supports coordinator indicated that staff have to be involved in these behavioral interventions. Appellant's supports coordinator testified that most of the respite time is not used to give the family a break, but to allow Appellant to participate in family events. Appellant's supports coordinator testified that this has become much more difficult since the baby was born.

Appellant's mother testified that since the baby was born, the situation with Appellant has changed dramatically. Appellant no longer sleeps through the night, or through the early morning, because the crying baby wakes him up and he becomes agitated and aggressive. Appellant's mother testified that Appellant insists on trying to hit and harm the new baby and needs someone with him at all times. Appellant's mother indicated that this includes times in the car. Appellant's mother testified that if there are visitors in the home, Appellant also needs to be watched at all times because he will go after the baby if the baby acts up.

Appellant also submitted a note from Dr. ██████████, D.O., which indicates that Appellant should not be left alone with the baby at any time. (Exhibit 2)

Appellant bears the burden of proving by a preponderance of the evidence that the additional 6 hours of CLS per week and 30 hours of respite per month are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing 15 CLS hours per week and 50 respite hours per month. Appellant failed to prove by a preponderance of the evidence that an additional 6 hours per week of CLS, and 30 hours per week of respite, are medically necessary.

As indicated above, B3 services are not intended to meet all of a consumer's needs and preferences and it is reasonable to expect parents of minor children with disabilities to provide the same level of care they would provide to children without disabilities. Here, the CMH took into consideration the situation with a new born in Appellant's home and still concluded that the amount of CLS and respite authorized were sufficient in amount, scope and duration to meet Appellant's needs. Appellant is also now back in school, so the parents will get a natural break from caregiving during that time. The current amount of CLS authorized, combined with Appellant's other services, should be sufficient in amount, scope and duration to reasonably meet the goals listed in

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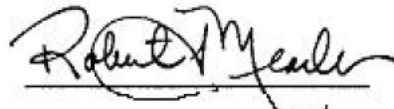
Appellant's PCP. The amount of respite currently authorized, combined with Appellant's other services, and the fact that he is now back in school, is sufficient in amount, scope and duration to give Appellant's parents short-term, intermittent breaks from caring for Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for 21 CLS hours per week and authorized 15 CLS hours per week. CMH also properly denied Appellant's request for 80 respite hours per month and authorized 50 respite hours per month.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc:



RJM

Date Signed:



Date Mailed:



***** 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.