

**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.** 2014-12764 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 a request for a hearing filed on behalf of Appellant.

After due notice, a hearing was held on ██████████. For purposes of hearing only, this matter was consolidated with Docket No. 2014-12765 CMH, a matter involving Appellant's sibling.

Attorney ██████████ appeared on Appellant's behalf. Appellant; ██████████, Appellant's mother and co-legal guardian; ██████████, Appellant's father and co-legal guardian; ██████████, an aide; ██████████, Appellant's sister; ██████████, a registered nurse; and ██████████, paralegal; were also present or testified on Appellant's behalf.

██████████, attorney and Due Process Hearings Coordinator, represented the Respondent ██████████, Compliance Coordinator, and ██████████, Supports Coordination Supervisor, from the ██████████) testified as witnesses for ██████████

Following the hearing, the undersigned Administrative Law Judge issued an Interim Order requiring the ██████████ to produce evidence by ██████████ regarding its communication with the Michigan Department of Community Health (MDCH) regarding any proposals or requests for services submitted on behalf of Appellant.

**ISSUE**

Did the CMH properly deny Appellant's requests for additional services?

**FINDINGS OF FACT**

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

██████████  
Docket No. 2014-12764 CMH  
Decision and Order

1. Appellant is a █████ year-old Medicaid beneficiary who has been diagnosed with Autism, Mood Disorder, Mild Mental Retardation, Cerebral Palsy, and Sleep Apnea. (Respondent's Exhibit A, pages 1-2).
2. Appellant's parents are his legal guardians. (Respondent's Exhibit A, page 2).
3. Appellant has been receiving services through █████ and █████ . (Testimony of █████).
4. The █████ is under contract with the MDCH to provide specified Medicaid covered services to people who reside in its service area.
5. In turn, the █████ contracts with service providers such as █████ to provide Medicaid covered services.
6. In █████, at the latest, Appellant's guardians and █████ began discussing possibilities for an arrangement for care for both Appellant and his sister, who also receives services through █████ and █████, outside of their parents' home. (Petitioner's Exhibit 1, pages 1; Testimony of █████; Testimony of █████).
7. █████ took the lead in drafting a document regarding potential care options for Appellant and his sister, submitting that document to █████ and arranging meetings. (Petitioner's Exhibit 1, pages 2-7; Testimony of █████; Testimony of █████).
8. █████ staff then made their own contributions to the discussion and additions to the document. (Petitioner's Exhibit 1, pages 2-7; Petitioner's Exhibit 3, page 1; Testimony of █████; Testimony of █████).
9. Ultimately, that document contained an identification of home and vehicle requirements; a note that the current allocation of Adult Home Help Services (HHS) each sibling was receiving could reduce the total cost of staffing; four examples of potential living arrangements, only some of which took into account current regulations or payment structures; and the identification of a number of areas for discussion and resolution. (Petitioner's Exhibit 1, pages 9-12).
10. In a █████ email, █████, a Manager within █████, indicated that she would be forwarding the document on to the MDCH. (Petitioner's Exhibit 3, page 1).
11. Similarly, in preparation for a meeting with staff members from the MDCH on █████ staff drafted a document containing background information; questions; and areas of discussion for that meeting. (Petitioner's Exhibit 2, pages 1-2).

██████████  
Docket No. 2014-12764 CMH  
Decision and Order

12. On J ██████████, a meeting was held between Appellant's guardians and ██████████ with respect to Appellant's Individual Plan of Service (IPOS) for the time period of ██████████ and ██████████ (Respondent's Exhibit A, pages 1-31).
13. During the meeting, it was noted that Appellant's ultimate goal was to move from his family home to a more independent community setting that can meet his needs and that ██████████ was working closely with Appellant and his family in trying to secure a private residence that was in the process of being built. (Respondent's Exhibit A, page 4).
14. With respect to Appellant's current circumstances, however, Appellant was to be authorized supports coordination, fiscal intermediary services, Community Living Supports (CLS), and respite care services. (Respondent's Exhibit A, pages 4, 7, 10, 12-13, 16, 23).
15. Appellant was also notified of his grievance and appeal rights at that time. (Respondent's Exhibit A, pages 29-31).
16. On ██████████, a Periodic Review of Appellant's IPOS was held. (Respondent's Exhibit C, pages 1-8).
17. At that time, it was again noted that Appellant's family continued to work with ██████████, their state senator and others to investigate residential options for Appellant and his sister. (Respondent's Exhibit C, page 1).
18. It was also noted that Appellant had recently been discharged from the hospital and was still recuperating. (Respondent's Exhibit C, page 1).
19. It was further noted that Appellant was having issues with the Department of Human Services (DHS) regarding Appellant's HHS and was in the process of appealing a negative DHS decision. (Respondent's Exhibit C, pages 1, 5).
20. Given the changes in Appellant's health and HHS, ██████████ and ██████████ determined that Appellant's services should be adjusted. (Respondent's Exhibit C, page 2).
21. Specifically, Appellant's CLS were increased to ██████████ hours a week and his respite care services were replaced with respite nursing services. (Respondent's Exhibit C, page 5).
22. Appellant was also authorized for ██████████ hours a week of Private Duty Nursing (PDN). (Respondent's Exhibit C, page 5).

23. Appellant and his guardians were again notified of his formal appeal rights. (Respondent's Exhibit C, page 7).
24. On ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on Appellant's behalf.
25. That request asserted that Appellant's guardians have worked diligently with ██████████ and ██████████ for over ██████ years to develop a plan of services for Appellant and his sister, and that, while a proposal for a coordinated plan of services was developed and submitted, there has been no resolution.
26. According to the request for hearing, that lack of resolution has led to a denial of both medically necessary services and Appellant's due process rights.
27. The request for hearing further stated that, given Appellant's recent hospitalization, the current authorization of services was insufficient.
28. After the request for hearing was filed, another Periodic Review was held regarding Appellant's IPOS on ██████████. (Respondent's Exhibit B, pages 1-8).
29. Once again, that review noted that Appellant's family and supports team was still investigating different areas and options for independent settings. (Respondent's Exhibit B, page 1).
30. Following that review, Appellant's services remained at the same level. (Respondent's Exhibit B, page 6).
31. While previously approved in ██████████ Appellant did not utilize the authorized PDN until ██████████ because his care needs were being met by his primary insurance during that time period. (Testimony of ██████████).

### **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) 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.

Here, Appellant has been authorized a number of services through ██████████ and ██████████, including PDN and CLS authorized through the Habilitation Supports Waiver (HSW).

With respect to CLS, the Michigan Medicaid Provider Manual (MPM) states in part:

**SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental

Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

## **15.1 WAIVER SUPPORTS AND SERVICES**

### **Community Living Supports (CLS)**

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a

landlord or licensee, has responsibility for provision of these services);

- Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
- Shopping for food and other necessities of daily living.
- Assistance, support and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, 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 DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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 must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. 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.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

Similarly, with respect to PDN, the MPM states in part:

**SECTION 1 – GENERAL INFORMATION**

This chapter applies to Independent and Agency Private Duty Nurses.

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth in this manual.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from one of the following programs, that program authorizes the PDN services.

- Children’s Waiver (the Community Mental Health Services Program)
- Habilitation Supports Waiver (the Community Mental Health Services Program)
- Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)

For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Children’s Waiver, Habilitation Supports Waiver, MI Choice Waiver).

For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.

### 1.1 DEFINITION OF PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.

*MPM, Private Duty Nursing Chapter, page 1*

Here, Appellant requested a hearing regarding the alleged denials of his requests for additional services, both through a coordinated plan of care with his sister's services and following his recent hospitalization.

Each of those issues will be discussed in turn and, with respect to both, Appellant bears the burden of proving by a preponderance of evidence that the ██████████ erred.

#### **Coordinated Plan of Services**

As discussed above, Appellant's request for hearing states that Appellant's guardians worked diligently with ██████████ and ██████████ for over ██████████ years to develop a plan of services for Appellant and his sister, and that, while a proposal for a coordinated plan of services was developed and submitted, there has been no resolution and that lack of resolution has led to a denial of both medically necessary services and Appellant's due process rights.

However, as a preliminary matter, it is not clear that the undersigned Administrative Law Judge has jurisdiction over any such issue in this case. The Code of Federal Regulations (CFR) only affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. See 42 CFR 438.400.

In this case, while Appellant asserts that Appellant's guardians, ██████████ and ██████████ developed a plan of services for Appellant and his sister and that submitted that plan to the MDCH, without receiving any response, it does not appear that there was a specific denial of any requested Medicaid covered service.

██████████  
**Docket No. 2014-12764 CMH**  
**Decision and Order**

Emails contained in Petitioner's exhibits and testimony during the hearing do reflect that, in ██████████ took the lead in drafting a document regarding potential care options for Appellant and his sister, submitting that proposal to ██████████, and arranging meetings; with ██████████ staff then making their own contributions and forwarding on the document to the MDCH in ██████████

However, that alleged model or proposal was not a specific request for services and, instead, merely identified a number of requirements for the two siblings, four possible living arrangements, and a number of areas for discussion and further exploration. Overall, it just reflects a work in progress and ongoing discussions.

Similarly, Petitioner's Exhibit 2, a document generated by ██████████ in preparation for a meeting with the MDCH on ██████████ only identifies questions and areas of exploration that ██████████ and ██████████ had identified with respect to the difficulties it would have in providing services to Appellant in a new living arrangement.

Additionally, the evidence produced by ██████████ in response to the Interim Order issued by the undersigned Administrative Law Judge only reflects discussions, meetings, and questions regarding possible arrangements for Appellant and his sister without ever identifying a specific request for service made by Appellant.

Subsequent assessments and periodic reviews admitted during the hearing regarding Appellant's IPOS also demonstrate that the parties are still working together to explore various options with respect to the care of Appellant and his sister, without any suggestion that Appellant had requested specific services from ██████████ or the Department.

That continuing discussion, while appropriate and necessary, is insufficient to confer jurisdiction in this case, even if it is taking much longer than Appellant would like. Appellant is free to make a specific request for Medicaid covered services, but there has been no such request in this case and, without one, there is no negative action within the undersigned Administrative Law Judge's jurisdiction. Accordingly, the portion of Appellant's request for hearing regarding a coordinated plan for services should be dismissed for lack of jurisdiction.

### **Private Duty Nursing**

Appellant also asserts in his request for hearing that, given his recent hospitalization, the amount of services subsequently authorized is insufficient. As testified to by ██████████, the request is specifically referring to the amount of PDN that was authorized.

Appellant was first authorized for PDN after the ██████████ Periodic Review of his IPOS. At that time, ██████████ noted that he had recently been discharged from the hospital and was still recuperating. It therefore adjusted and increased his services to meet his new needs. Specific changes included the addition of ██████████ hours a week of PDN and his respite care services being replaced with respite nursing services.

**Docket No. 2014-12764 CMH**  
**Decision and Order**

In response, Appellant now argues that the authorization of PDN is insufficient. However, in doing so, Appellant fails to meet his burden of proving by a preponderance of the evidence that [REDACTED] and [REDACTED] erred.

Appellant's provider/guardian generally testified that [REDACTED] hours per week of PDN is insufficient while also acknowledging that, at both the time of the approval of PDN and the time the request for hearing was filed, Appellant was not utilizing any of that PDN. While approved in [REDACTED]r, Appellant did not utilize his PDN until [REDACTED] because his care needs were being met by his primary insurance during that time period. Given that Appellant was not utilizing any of the significant amount of PDN that had been authorized, it is clear that additional PDN was not necessary at all times relevant to this action.

To the extent Appellant's circumstances have changed, he is free to request additional services where appropriate. With respect to the issue in this case, however, Appellant has failed to meet his burden of proof and the Respondent's decision to only authorize [REDACTED] hours per week of PDN must be affirmed.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the [REDACTED] properly denied Appellant's request for additional services.

**IT IS THEREFORE ORDERED THAT:**

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

*Steven Kibit*

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

Date Signed: [REDACTED]\_\_\_

Date Mailed: [REDACTED]\_\_\_

SK/db

cc:

[REDACTED]

**Docket No. 2014-12764 CMH**  
**Decision and Order**

**\*\*\* 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.