RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: January 6, 2017
MAHS Docket No.: 16-016233
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

DECISION AND ORDER

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

After due notice, a hearing was held on January 3, 2017. Petitioner's Mother and Legal Guardian [redacted] appeared on behalf of the Petitioner. Attorney [redacted] (P[redacted]) represented the [redacted] ([redacted] or Respondent). [redacted], Operations Manager and [redacted], Supports Coordination appeared to testify on behalf of [redacted].

Petitioner's Exhibits 1-65 and Respondent's Exhibits A-E were admitted as evidence.

ISSUE

Did the [redacted] provide proper level of services to Petitioners?

FINDINGS OF FACT

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

1. Petitioner [redacted] is a Medicaid recipient through SSI eligibility, and is enrolled in the Habilitation Supports Waiver Program.

2. [redacted] ([redacted]) is 21 years old (DOB [redacted]). He receives Enhanced Home Help Services (5 hours per day) through the Michigan Department of Health and Human Services. He receives Respite Care (48 hours per month) and Community Living Supports (4 hours per day). He receives 12 hours of Private Duty Nursing per day. He received 5 hours per day of Enhanced

Home Help Services. Petitioner also received Occupational and Physical Therapy.

3. Petitioner receives a total of 21 hours of combined services per day which are covered by Medicaid which leaves three hours per day for Natural Supports.

4. Petitioner [redacted] is g-tube fed. He does not require a ventilator. He is diagnosed with Aicardi-Goutières Syndrome with developmental delays, cerebral palsy, brain atrophy with mental retardation, poor vision, hypertonicity of legs, history ear infections, sleep apnea with Bi Pap and seizure disorder, multiple allergies, blindness and incontinence.

5. Petitioner resides in the home with his parents.

6. Both parents are caregivers.

7. Petitioner is totally dependent on caregivers for health and possible safety hazards. He is non-verbal, non-ambulatory and has multiple medical conditions and health issues. He is unable to communicate needs, so caregivers must anticipate needs at all times. He must be supervised at all times.

8. On November 2, 2016, Petitioner's Guardian filed a Request for Hearing, seeking 16 hours per day in Private Duty Nursing (PDN); an increase in Community Living Supports (CLS); a decision from the Administrative Law Judge that she be able to use PDN flexibly (16 hours one day or 6 hours the next as needed); a decision from the Administrative Law Judge that she be able to use the respite care hours even when she is present; and 23 hours of coverage daily for Petitioner's care.

9. Petitioner's Guardian alleges that she is only willing to provide one hour of services per day to Petitioner.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

The NLCMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Michigan Mental Health Code explicitly states:

330.1712 Individualized written plan of services.

Sec. 712.

(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975 -- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

The Michigan Mental Health Code, Section 330.1100a, defines developmentally disabled as:

(21) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

(i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.

(ii) Is manifested before the individual is 22 years old.

(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

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 Medicaid Provider Manual 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; 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.

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; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- 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;

    - 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.

The Medicaid Provider Manual state in pertinent 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 MDHHS 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/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID 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 MDHHS Bureau of Community Based 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services
October 1, 2016, page 102

1. **Private Duty Nursing - Did the NLCMH properly determine that Petitioner was entitled to receive 12 hours per day of Private Duty Nursing?**

Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.

- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III. **Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day**, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least

one of the following habilitative services, whether being provided by natural supports or through the waiver.

- Community Living Supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, CHAMPUS, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant

services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition. (page 115)

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

  - A temporary increase in the intensity of required assessments, judgments, and interventions.

  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:

  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the

caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

  - A temporary increase in the intensity of required assessments, judgments, and interventions.

  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:

  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/NLCMHSP.

  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

"Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers. (Page 116)

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

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Developmental Disability Supports and Services
October 1, 2016, pages 112-117

The State Habilitation Supports Waiver Amendment, Extended Agreement between Michigan and CMS, Appendix D-1, part e, provides at page 122:

> **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The PCP process is the main method through which issues related to risk are identified, strategies for mitigating risk are developed, and methods for monitoring are determined. This process is described below in detail and it is effective because it involves the people most trusted and valued by the participant, including family, friends and other allies. The process is an open one in which the pros and cons of alternatives can be discussed. In this manner, health and welfare issues are balanced with the participant's right to make his or her own choices. Solutions to these health, safety and welfare issues are brought up, discussed and resolved to assure the health and welfare of the participant in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction. In the person-centered planning process, the participant is informed of identified potential risk(s) to enable the participant to make informed decisions and choices with regard to these risks. Often the

discussion leads to better alternatives that both meet the participant's needs and satisfy his or her dreams and goals.

A participant may choose to address a sensitive health and welfare issue privately with the supports coordination provider, rather than within the group PCP process. Regardless of how it is done, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) has an obligation to ensure that all health and welfare issues are addressed. When the participant makes a decision contrary to the recommendation of a member of his or her circle of support, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) must ensure that the participant has information about all available options, documents the participant choice, and revisits the issue as needed.

Sometimes, a participant's choices about how their supports and services are provided cannot be supported by the HSW because the choices pose an imminent risk to the health and welfare of the participant or others. However, these decisions are made as part of the planning process in which the participant and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the participant's needs and satisfy their dreams and goals. Participant-approved risk strategies are documented and written into the IPOS. Participants may be required to acknowledge situations in which their choices pose risks for their health and welfare.

2. **Is the NLCMH required to provide 23 hours of daily coverage for BM?**

NLCMH has an obligation to authorize Medicaid Services in the amount, scope and duration that are medically necessary and sufficient to meet the beneficiary's goals and objectives as established in the current Individual Plan of Services (IPOS). In December 2015 the guardian, assisted by legal counsel chose not to appeal the amounts of Community Living Supports (CLS) and Respite Care Services (RCS) authorized in the POS. NLCMH notes that monitoring and supervision are not Medicaid Services. Actual hands-on care is covered by Medicaid.

NLCMH is not obligated to provide 23 hours of daily coverage unless it is in compliance with the IPOS and medically necessary under the Medicaid Provider Manual Regulations. There has been no denial, reduction, suspension or termination of a requested Medicaid covered service.

3. **Did the NLCMH fail to provide Respite Care for Petitioner; Was the Petitioner's guardian improperly provided with Respite Care hours?**

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).

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 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.

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This Administrative Law Judge finds that Petitioner receives 48 hours per month of Respite Care (which is in the process of being converted to PDN Respite Care when staff are sufficiently trained), for when the caregivers are not available in accordance with Medicaid policy. Petitioner has in the past been granted Respite Care and Emergency Respite Care. The Natural Supports (parents) have not been forced into involuntary servitude. They have several alternative options available to them, even if those options are not optimum or desired. For example: They also have the option of providing care to Petitioner through more advanced (nursing home) care if Petitioner can no longer be safely provided care in the current residential placement. Medicaid is a payer of last resort and pays only for medically necessary care. NLCMH has not violated Department or Medicaid policy by requiring that caregivers be unavailable before Respite Care can be used. That is the entire purpose for Respite Care – to give respite to caregivers when they are ***unable*** *or* ***unavailable*** to provide that care which the beneficiary needs. Respite Care is based strictly upon the needs of the beneficiary, not the needs of the caregivers. There has been no denial, reduction, suspension or termination of a requested Medicaid covered service.

4. Did the NLCMH properly grant Petitioner Four hours of Community Living Supports?

The Medicaid Provider Manual (MPM) Provides direction for Services for Developmentally disabled individuals:

> **2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES**
>
> Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:
>
> - Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
>
> - Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.

- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).

- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES states:

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;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- 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. MDHHS 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.

The *Medicaid Provider Manual* articulates Medicaid policy for Michigan. Its states with regard to community living supports:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> 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
> - 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 services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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 MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS 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 MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment. (Emphasis Added)

- 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 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 MDHHS 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 MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

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.

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[redacted] is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the

amount or level of the Medicaid medically necessary services that are needed to reasonably achieve life goals.

Petitioner bears the burden of proving by a preponderance of the evidence that more than 4 hours of CLS per day are medically necessary. [redacted] provided sufficient evidence that it adhered to federal regulations and state policy when authorizing 4 hours per day of CLS for Petitioner. Petitioner failed to prove by a preponderance of the evidence that additional hours per day of CLS was medically necessary. Petitioner's representative asserts that Petitioner cannot be housed safely in his current living arrangement without enhanced monitoring and direct care assistance.

Department policy clearly dictates that the intention of Community Living Supports is skills building acquisition for increased independence. Petitioner may never acquire skills which will allow him to live independently or even with increased independence based upon the fact that he is developmentally disabled and physically disabled. Medicaid Waiver services are not intended to meet all of consumer's needs and preferences and the [redacted] must take in to account its ability to serve other beneficiaries. Petitioner receives extensive support in the amount of 21 hours per day (plus Respite Care Services). However, if the [redacted] was required to provide one-on-one around the clock care to all beneficiaries with needs similar to Petitioner, it is highly unlikely that there would be enough resources to serve everyone in the [redacted] service area. Finally, if Petitioner is unable to live on his own without one to one 24 hour support and monitoring (as alleged by Petitioner's guardian when she requests 23 hours of care per day and states that Petitioner needs 24 hour care), then the current housing arrangement may not be the least restrictive setting for him. Based on the evidence presented, the current amount of combined services (21 hours per day) authorized is sufficient in amount, scope and duration to reasonably meet Petitioner's needs.

The [redacted] has established by the necessary competent, substantial and material evidence on the record that it was acting in compliance with Department and Medicaid policy when it determined that Petitioner is entitled to 12 hours per day of PDN and 4 hours per day of CLS as well as 48 hours per month of Respite PDN services once staff is sufficiently trained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the [redacted] properly denied Petitioner 23 hours of care per day and properly authorized 12 hours of PDN and 4 hours of CLS services per day which, in conjunction with the other services received, equals 21 hours per day of services provided to Petitioner which is sufficient in amount, scope and duration to reasonably meet Petitioner's needs.

IT IS THEREFORE ORDERED that

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

LL/sb

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Petitioner [redacted]

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS Department Rep. [redacted]

DHHS-Location Contact [redacted]

Authorized Hearing Rep. [redacted]