STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-24076 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. The hearing was initially scheduled for [redacted] However, the Appellant's mother requested an adjournment of the [redacted] hearing date because the Appellant was scheduled for a medical procedure on that day. The request for adjournment was granted, and the hearing was then scheduled for [redacted], [redacted].

[redacted], appeared on behalf of [redacted]). Also appearing as witnesses for the Appellant was his [redacted], the [redacted].

[redacted], appeared on behalf of [redacted] Mental Health Services Provider [redacted]), an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded specialty mental health supports and services (hereafter, 'Department'). Also present on behalf of the Department was [redacted]

ISSUE

Has the Department properly denied the Appellant's request for 60 hours of Respite Care Services?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant, born [redacted], is a Medicaid beneficiary who is currently receiving Medicaid-funded specialty mental health supports and services through [redacted]. He is diagnosed as a child with a Serious Emotional Disturbance, and specifically diagnosed with Disruptive Behavior Disorder, NOS and hyperactivity disorder. *(Exhibit 1; p. 2)*

2. The Appellant commenced services with [redacted] due to hyperactivity and poor behavior in public, including aggression without provocation (property destruction, hitting, kicking, punching or biting his siblings/peers and bullying younger children). He also has difficulty during transport where he removes clothing, throws items within reach, and fights with other individuals in the vehicle. During bath time, the Appellant is "wild and if not monitored he will become injured." When the Appellant gets out of the bathtub, he intentionally urinates on the floor with a smile on his face. *(Exhibit 1; p. 2)*

3. The Appellant's parents also care for two other [redacted] children; the [redacted], and a [redacted]. The Appellant's [redacted] struggles with Oppositional Disorder of Childhood and is being further evaluated for several other concerns (fetal alcohol syndrome, cognitive impairments, other emotional disturbances and ADHD). The [redacted] oppositional behaviors and cognitive impairment create challenges for the Appellant's parents, because she also becomes angry and frustrated at times when unable to master certain tasks. *(Exhibit 1; p. 2)*

4. The Appellant's [redacted] requires constant supervision above what would be considered age appropriate; her behaviors create safety concerns, as she gets into inappropriate things and can be sneaky and quiet. Additionally, the Appellant's [redacted] resists direction concerning simple daily activities such as changing diapers, bathing and going to sleep. *(Exhibit 1; p. 2)*

5. The Appellant's [redacted] struggles with the diagnosis of Reactive Attachment Disorder, Post-Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder. Her behavioral problems also create challenges for the Appellant's parents and also require a high level of supervision. *(Exhibit 1; p. 2)*

6. The Appellant's foster parents wish to use Respite services to spend time with their other disabled children, and with each other. They also wish to use respite services to attend to other household obligations, including grocery shopping outside. Additionally, the Appellant's foster parents have sought respite supports from friends and family, but have been unsuccessful due to the extreme behavior of their children. *(Exhibit 1; p. 3)*

7. The Appellant, at age [redacted], is not potty trained, and must be supervised while eating. He was born at [redacted] cesarean section with a [redacted]. Polysubstance abuse in utero was suspected in the form of crack cocaine, alcohol and marijuana. The Appellant was noted not be breathing well after birth, received supportive care for three months in the Neonatal Intensive Care Unit, and was discharged home close to term, on oxygen and an apnea monitor. *(Exhibit 2; p. 1)*

8. The Appellant has weak ankles and falls frequently. He has no awareness of height differences and will fall or walk off a surface that is a different level and is at risk of being injured. The Appellant is hyperactive and has to be monitored closely because he runs off when not supervised and, because he has no sense of danger, is at risk of injury. *(Exhibit 1; p. 7)*

9. The Appellant has experienced long-standing issues with sucking and swallowing. He is noted to be hyperactive as well. The Appellant is described as impulsive with labile mood; everything he finds goes into his mouth, both food and non-food substances. As a result of this problem, the Appellant's parents utilize an oral exercise regimen to address and ameliorate his tendency to stuff food in his mouth. *(Exhibit 2; p. 1; 6)*

10. The Appellant's foster parents have requested 60 hours per month of respite services; the Department has authorized 56 hours per month. The Appellant's father works outside of the home approximately 40 hours per week. The Appellant's parents are not receiving personal care services through the Department of Human Services, Adult Home Help Services program. *(Testimony of Appellant's mother)*

11. On [redacted] the Appellant's foster mother filed a request for hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed

> by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

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. MCCMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

There is no dispute regarding the continuing eligibility for specialty mental health services. At issue is whether the Appellant's requested 60 hours per month of respite services is medically necessary, and whether the request defines goals that satisfy the intents and purpose of B3 Supports and Service.

The Section of the Medicaid Provider Manual addressing this issue provides, in pertinent part, as follows:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

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

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

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with the least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and

- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) that 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.

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(Policy version applicable to date of action substantively unchanged)

Respite Services are Medicaid covered, B-3 services. The Medicaid Provider Manual, Mental Health and Substance Abuse Services chapter provides the Respite Service description.

17.3.J. RESPITE CARE SERVICES

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary caregiver (e.g., family members and/or adult family foster care providers) and is provided

during those portions of the day when the caregivers are not being paid to provide 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.

Respite care may be provided in the following settings:

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

Respite care may not be provided in:

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

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

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

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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.*

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

The Appellant's foster mother presented credible evidence that the Appellant's behavioral issues significantly interfere with her ability to enlist the assistance of family, friends and other natural supports. The respite assessment specifically notes the Appellant's family has "been unable to find support from friends or family due to the extreme behaviors of their children." *(Exhibit 1; p. 3)* This factor does not appear to have been considered by the Department in deciding that 56 hours of respite services was sufficient.

Additionally, the evidence presented supports a finding that the Appellant's foster parents care for two other [redacted], both of whom exhibit challenging behaviors in their own right. The Department does not appear to have given this factor any consideration whatsoever.

Additionally, the evidence of record indicates the Appellant receives Supports Coordination and Medication Review services, but no community living supports. It appears the Department has not offered community living supports as a complement to, or in lieu of, respite services.

Instead, the Department witness testified the denial of 60 hours of respite was based on her blanket conclusion that all of the Appellant's behaviors are "typical" of a child his age. No consideration seems to have been to the Appellant's specific behaviors, some of which are not, in my opinion, typical of all children the Appellant's age. To the contrary, the respite assessment clearly indicates the behaviors are not typical of children the same age as the Appellant, but rather, are indicative of his specific medical and mental health ailments.

Current respite policy provides for temporary relief to the unpaid primary caregiver. A review of the evidence presented supports a conclusion the Appellant meets current criteria for 60 hours of respite care, rendering the [redacted] denial inappropriate.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Department improperly denied the Appellant's request for 60 hours per month of respite care services.

IT IS THEREFORE ORDERED that:

> The Department's decision is REVERSED. The Appellant shall be provided 60 hours per month of respite care.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/15/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.