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. 2009-36852 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted] Appellant's mother, appeared on behalf of the Appellant. [redacted] Due Process Manager, appeared on behalf of [redacted]. [redacted] Utilization Management, appeared as a witness for the CMH.

ISSUE

Did [redacted]) properly authorize respite hours for Appellant?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary receiving services through [redacted]) as an adult with a Developmental Disability.

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. The Appellant is a [redacted] Medicaid beneficiary. The Appellant has mental retardation and seizures, is non-verbal and uses a wheelchair. (Exhibit 1 Page 10; Ex 2).

4. Appellant is totally dependent on others for her personal care. (Exhibit 1 Page 10).

5. The Appellant lives with her mother and two siblings.

6. Appellant's mother is her primary caregiver.

7. The Appellant has received respite services from CMH in the past.

8. Appellant's current Individualized Plan of Service (IPOS) was authorized through [redacted]. (Exhibit 1 Page 2)

9. On [redacted] Appellant requested respite services in the amount of 96 hours per month of respite. (Exhibit 1 Pages 2 and 3).

10. On [redacted], a respite services assessment was performed for Appellant to determine the amount of respite hours per month needed. (Exhibit 1 Pages 2-9, 12-14).

11. Appellant was scored the maximum points (20) for mobility and personal care as part of the respite assessment. (Exhibit 1 Page 13).

12. Appellant was scored the maximum points (15) for being emotionally dependent on others as part of the respite assessment. (Exhibit 1 Page 13).

13. Appellant's total points scored as part of the respite assessment equaled 69 hours per month of respite. (Exhibit 1 Page 11).

14. On [redacted], Appellant was sent an Adequate Action Notice informing her she had been approved for 69 of the 96 hours of respite requested. (Exhibit 1 Page 15). Appellant's notice included a notice of hearing rights. (Exhibit 1 Page 16).

15. The Appellant's request for hearing was received by this office on [redacted] (Exhibit 2).

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

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse* section articulates Medicaid policy for Michigan. It states with regard to respite and personal care:

> **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 care giver. 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.
>
> *July 1, 2009, Pages 110 and 111.*

The CMH representative stated that Appellant received a respite services assessment pursuant to her request for 96 hours per month of respite, the maximum number or hours allowed under Department policy. CMH witness [redacted] testified that CMH uses a scoring tool to assess need for respite and that Appellant scored the maximum points (20) for mobility and personal care as part of the respite assessment. (Exhibit 1 Page 13). CMH witness [redacted] testified that the maximum number of respite points that could be awarded in the category of behavior was 30 for frequent verbal and/or physical behaviorally/emotionally dependence. CMH witness [redacted] stated that in cases where 30 points are awarded there is a substantial amount of documented behavioral or emotional issues. Because there was no documentation that Appellant had frequent verbal and/or physical behavioral and/or emotional dependence, CMH witness [redacted] explained that Appellant did not receive 30 points. CMH witness [redacted] further explained that there was documentation that Appellant had "quite mild" behaviors, such as biting her hand, when frustrated and therefore she received 15 points, the maximum amount allowed for behaviorally/emotionally dependence upon others. (Exhibit 1 Page 13)

The CMH representative testified that Appellant scored the maximum points (15) for being emotionally dependent on others which brought her respite assessment to a total of 69 hours of respite per month. (Exhibit 1 Page 11).

During the hearing the Appellant's mother/representative testified that Appellant has high care needs, she is her primary caregiver, and she has two other children to care for. The Appellant's mother/representative asserted she needs the 96 respite hours. No evidence was produced to document that Appellant's behaviors were frequent, verbal and/or physical.

This Administrative Law Judge must follow the CFR and the state Medicaid policy, and is without authority to grant respite hours out of accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when authorizing respite at 69 hours per month for the Appellant. The Appellant, who bears the burden of proving by a preponderance of evidence that there was medical necessity for 96 hours of respite, did not meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized respite at 69 hours per month for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/12/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.