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

Docket No. 2010-28797 CMH
Case No. [redacted]

[redacted],

Appellant
_____/

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] appeared on behalf of the Appellant. Her witnesses were [redacted], respite worker, and [redacted], behavior therapist. [redacted], attorney, represented the Department. Her witness was [redacted], PhD., Access Services Center Manager.

ISSUE

Did [redacted] County Community Mental Health ([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 [redacted] Medicaid beneficiary.

2. The Appellant is not enrolled in any of the Medicaid specialty waivers. Department's Exhibit D

3. The Appellant is identified as a person with autism and kidney cysts. Department's Exhibit A, p. 1

4. The Appellant has been served by the [redacted] since [redacted], and has received assessments, treatment planning, supports coordination, speech and language evaluation and services as well as occupational therapy evaluation and services. The family has received home care training and respite. Department's Exhibit A - G

5. The Appellant's mother reports that she is stressed and overwhelmed owing to constant demands of supervising the Appellant. Department's Exhibit A p. 1 and Appellant's Exhibit #1 – and *See* Testimony.

6. On [redacted], the Department advised the Appellant, by adequate action notice, a denial of the requested Respite hours [1500 units] and instead documented the provision of 754 units of Respite [owing to lack of special circumstances] – or approximately 50 hours per month as opposed to the requested 96 hours. Department's Exhibit A, pp. 1, 4 - 6

7. The Adequate Action notice also included the Appellant's further appeal rights. Department's Exhibit A, p. 5.

8. [redacted] is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

9. The Department established that the Appellant's respite services were determined based on criteria established in the Appellant's person centered plan. Department's Exhibit F and *See* Testimony.

10. The Department established that the [redacted] respite assessment was reasonable, based on the hours of need and medical necessity. *(See* Testimony and Department's Exhibit F)

11. The Department witness established that respite services remained adequate and in line with policy because the services authorized were within guidelines and subject to adjustment based on need. The PCP specified PT and behavioral assessment and family training - subject to quarterly review and monitoring or more often as needed. Department's Exhibit F and *See* Testimony of [redacted].

12. The Department witness added that owing to the Appellant's age and the expectation that parents will provide the same level of care to the Appellant as they would children without disabilities that respite services were presently adequate (*See* Testimony of [redacted] and Department's Exhibit A – F)

13. The instant appeal was received by SOAHR on [redacted]. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). 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. [redacted] County 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, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[1] it states with regard to respite:

[CRITERIA FOR AUTHORIZING]

> The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:
>
> - The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
> - The service(s) having been identified during person-centered planning; and
> - The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
> - The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
> - Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter. (Emphasis supplied) MPM, Mental Health [ ] §17.2 Criteria for Authoring B3 Supports and Services, p. 98, April 1, 2010[2]

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[1] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12 – 14, April 1, 2010
[2] These sections of the MPM are substantially similar to those in effect at the time of adequate action and appeal.

[RESPITE]

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. (Emphasis supplied) MPM Mental Health [ ] §17.3J, Respite Care Services, pp. 110, 111, April 1, 2010

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At hearing [redacted] testified that the submitted documentation did not establish any special need or circumstance – that could not be addressed through respite planning established at 50 hours per month – including the derivative services of OT, family training, and behavior assessment.

She said that at age [redacted] it is not unrealistic for a child to demand constant attention and care. She further opined that parents are expected to provide the same level of care for children with behavioral issues as they would with their non-disabled children.

The Appellant's representative testified that the Appellant acted "more like a [redacted] old than a [redacted]" and that he has "no good sleeping or eating pattern."

Her witness [redacted], respite worker, testified that as of [redacted], the Appellant was beginning to verbalize and that additional hours of respite could produce even better results.

Appellant's witness [redacted], behaviorist, testified that the Appellant's behaviors and tantrums have decreased from 13 to 10.5 while tantrums maintained stability at 5.

[redacted] found no inconsistency with the reports offered by the witnesses, but found that there was no indication for additional respite present during the PCP assessment – although conditions could be reassessed as they changed.

During the hearing, the Appellant's representative testified that Appellant has high care needs, however 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 50 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 50 hours per month for the Appellant.

IT IS THEREFORE ORDERED that:

The [redacted] decision is AFFIRMED.

_____

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No.2010-28797 CMH
Hearing Decision & Order

cc: [redacted]

Date Mailed: 06/28/2010

***** 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.