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

IN THE MATTER OF:

[redacted]

Docket No. 2011-43517 CMH
Case No. 40689832

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] and [redacted], Appellant's parents, appeared on behalf of the Appellant. The Appellant was also present.

[redacted], Due Process Hearings Coordinator, appeared on behalf of Genesee County Community Mental Health. [redacted], Manager, Utilization Management Department, appeared as a witness for the CMH.

ISSUE

Did Genesee County Community Mental Health (CMH) 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] County Community Mental Health (CMH).

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] year old Medicaid beneficiary (DOB [redacted]). The Appellant's diagnoses are profound mental retardation, seizures and multiple medical diagnosis. (Exhibit 1, p 1).

4. The Appellant attends an ECDD program, but Appellant's parents must provide

transportation and be present for the class. (Exhibit 1, page 3).

5. The Appellant lives with her parents in a three story rental home. (Exhibit 1, testimony).

6. On [redacted], Appellant's parents met with members of CMH to complete a respite assessment. (Exhibit 1, pp 1-9).

7. During the assessment, CMH reviewed all of the services the Appellant was receiving and documentation of her behaviors and needs. The CMH determined that 96 hours of respite services was not medically necessary but that 66 hours of respite services were appropriate. (Exhibit 1, p 1).

8. On [redacted], Appellant was sent an Advance Action Notice informing her that her request for 96 hours of respite services from CMH was denied because they were not medically necessary. The Notice informed Appellant that it had been determined that 66 hours of respite services had been approved. (Exhibit 1, Page 10). Appellant's notice included a notice of hearing rights. (Exhibit 1, Page 11).

9. The Appellant's request for hearing was received by this office on [redacted]. (Exhibit 2). In the request for hearing the Appellant's mother stated that she was asking for 96 hours of respite per month. (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 Appellant's mother explained that both she and her husband have medical problems and that they need the additional respite hours in order to go to various medical appointments and procedures, as well as to do grocery shopping and run other family errands. The Appellant's father recently had rotator cuff surgery and will not be able to carry Appellant, who weighs 40 pounds, for some time. The Appellant's mother indicated that she also has knee problems and it is very difficult for her to carry Appellant up and down two flights of stairs at least twice per day. The Appellant's mother also explained that she and her husband have limited family supports in the area and that the severity of Appellant's condition makes it very difficult for others to care for her. Appellant must be fed through a tube four times per day.

CMH witness [redacted] stated that he is a manager within the Utilization Management Department at CMH and his duties include reviewing clinical records and determining what services are medically necessary. [redacted] reviewed the respite assessment and explained what points were awarded Appellant in the various categories.

[redacted] testified that Appellant was awarded 20 hours of respite in Section 1 of the assessment because she has a developmental disability. Appellant was awarded 2 hours of

respite because both parents own and rent several houses that require constant work, 2 hours because Appellant's parents both have health issues that interfere with their care of Appellant, and 4 hours because Appellant requires 3-4 night time interventions per night. Appellant was also awarded 4 hours of respite because she needs 1:1 assistance to enter/exit transportation services, she needs to be pushed in a wheelchair within the house, cannot reposition herself, needs specialized treatment to maintain mobility and needs 1:1 supervision during outings. (Appellant's parents need to carry her wherever they go). Appellant was awarded 4 hours of respite because she needs to be tube fed and 4 hours because she wears diapers for her toileting needs. Appellant was awarded 4 hours because she requires assistance getting in and out of the tub and 4 hours because she needs complete assistance getting dressed. Finally, Appellant was awarded 2 hours because she requires physical assistance with brushing her teeth and 2 hours because she requires physical assistance with her hair care.

[redacted] testified that it was discovered after the Notice of Action was sent to Appellant that a miscalculation had occurred in the respite assessment and that actually the scoring showed that Appellant was only entitled to 54 hours of respite care per month. However, Mr. Holiday explained that CMH would continue to provide the 66 hours of respite care per month authorized originally, despite the mistake.

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

> **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.
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> *July 1, 2010, Page 110.*

Witness [redacted] explained that because Community Mental Health services are paid for with Medicaid, Community Mental Health can only approve services that are deemed to be clinically necessary.

This administrative law judge must follow the CFR and the state Medicaid policy, and is without authority to grant respite hours not in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it authorized 66 hours of respite care per month. This administrative law judge finds that the 66 hours of respite care awarded are sufficient to provide for the adequate care of Appellant. The CMH properly took into account Appellant's significant needs, such as her need to be tube fed, as well as the health conditions of her parents, in completing the respite assessment. The Appellant, who bears the burden of proving by a preponderance of evidence that there was medical necessity for 96 hours of respite care, 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 Appellant's CMH-provided services, including respite services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

[redacted]
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **9/1/2011**

***** 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.