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. 2011-51687 CMH
Case No. 74147721

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 Wednesday, [redacted]. [redacted], Appellant's mother, appeared on behalf of the Appellant.

[redacted], Due Process Hearings Coordinator, appeared on behalf of [redacted] County Community Mental Health (CMH or the Department). [redacted], Utilization Care Coordinator, appeared as a witness for the Department.

ISSUE

Did the CMH properly determine Appellant's respite hours?

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 who has been receiving services through [redacted] County Community Mental Health (CMH) for many years. (Exhibit A, Testimony)

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 whose date of birth is [redacted]. (Exhibit A, p 1). The Appellant is diagnosed with severe mental retardation and has epilepsy. The Appellant is prescribed risperdal,

trileptal/topamaz, dsyreal and clonidine. (Exhibit A, p 3).

4. The Appellant lives with his mother and sister. (Exhibit A, page 3).

5. Appellant's mother is his primary caregiver and she works part-time at [redacted] Schools. (Exhibit A, p 3). Appellant's grandmother lives in the area but is very ill and is unable to provide any support to the family. (Testimony).

6. Appellant will often be up all night and his mother will not be able to get any sleep. Appellant will wander the house, getting into cupboards and the refrigerator, making noise, turning on the lights and clapping. Appellant can get physical if he does not get his way. Appellant will throw a tantrum and fall to the ground. Appellant is 6.5" and his mother struggles at times with his activities of daily living. (Exhibit A, p 3)

7. On [redacted], Appellant's mother requested 88 hours per month of respite. On [redacted], CMH conducted a Respite Assessment. As a result of the Assessment, Appellant's mother was approved for 50 hours of respite per month. (Exhibit A, pp 1-5)

8. On [redacted], CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the request for 88 hours per month of respite was denied, but that 50 hours of respite per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit A, pp 6-7).

9. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (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 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. 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.*

CMH witness [redacted], Utilization Care Coordinator, has a Masters of Science degree and is a Limited License Psychologist (LLP). [redacted] reviewed and scored Appellant's Respite Assessment and testified that Appellant was awarded 6 respite hours because one of Appellant's care givers works or is in school full-time or part-time, 2 respite hours because Appellant's primary caregiver has a health, psychological or emotional condition that interferes with the provision of care, 4 respite hours because

Appellant required 3 or more interventions per night, 2 respite hours because Appellant is physically abusive to others on a weekly basis, 1 respite hour because Appellant strips in public on a weekly basis, 1 respite hour because Appellant has weekly temper tantrums, and 2 respite hours because Appellant wanders on a daily basis. [redacted] testified that Appellant was also awarded 2 respite hours because Appellant requires shadowing because he has an unsteady gait, 4 respite hours because he requires assistance with oral care, 2 respite hours because Appellant can eat independently after set up, 3 respite hours because Appellant requires assistance with bathing, 3 respite hours because Appellant requires assistance with toileting, and 3 respite hours because Appellant requires assistance with dressing. Finally, [redacted] testified that Appellant was granted 3 respite hours because of dietary needs, 4 respite hours because he requires total physical assistance with grooming, 3 respite hours because he requires medication administration (over age 18), 2 respite hours because he is non-verbal, and 3 respite hours because he requires extensive prompting and encouragement to participate in tasks; for a total of 50 respite hours per month.

[redacted] explained that Appellant's overall number of respite hours may be lower than it had been previously because the respite assessment scoring tool changed in [redacted]. Under the prior scoring tool, individuals were granted 20 hours respite per month from the start; then additional hours were added depending on specific needs. Under the current scoring tool, individuals are no longer granted 20 hours of respite up front. [redacted] explained that [redacted] County realized that it was an outlier with regard to granting 20 respite hours up front and that it changed its policy to come in-line with other counties in the State. [redacted] also indicated that the new scoring tool is now much more objective and needs based. [redacted] testified that the person who conducts the interview for the assessment is not privy to the scoring system; hence there is no risk that the interviewer could manipulate the answers to affect the score. Finally, [redacted] testified that, in her professional opinion, the 50 respite hours approved per month accurately reflects the needs of the Appellant.

[redacted], Appellant's mother, testified that Appellant has been receiving respite for 7 or 8 years and has been receiving Medicaid services his whole life. [redacted] testified that she uses her respite hours to care for her other daughter and to participate in activities at church. [redacted] indicated that she does not have any natural supports in the area and that it is difficult to get anyone to help her with the Appellant because of his needs. [redacted] testified that she had never heard of community living supports (CLS) or home-help through DHS, but would be interested in those services if Appellant was eligible for them. Finally, [redacted] testified that she has never used respite hours to go to work.

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

> **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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> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 110.*

The CMH is mandated by federal regulation to perform an assessment for the Appellant 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 his goals.

Applying the facts of this case to the documentation in the respite assessment supports the CMH position that the Appellant's mother's respite needs could be met with the 50 respite hours per month authorized.

The Appellant bears the burden of proving by a preponderance of the evidence that the approved 50 hours of respite per month was inadequate to meet the Appellant's mother's needs. The Appellant's mother did not prove by a preponderance of the evidence that the 50 respite hours per month determined to be medically necessary by CMH in accordance to the Code of Federal Regulations (CFR) was inadequate to meet her needs. The Department adequately explained what led to a decrease in Appellant's respite hours and how it calculated the number of respite hours that are medically necessary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the 50 respite hours per month approved for Appellant's mother are appropriate.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **10/13/2011**

***** 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.