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. 2011-9060 CMH
Case No. 39365905

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 [redacted], appeared on behalf of the Appellant. The Appellant was present and provided testimony.

[redacted], appeared on behalf of [redacted] Community Mental Health. [redacted] and [redacted], appeared as [redacted] witnesses for the CMH.

ISSUE

Did [redacted] 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] 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. CMH contracts with Community Living Services of [redacted] (CLS) to provide case management services to its CMH enrollees.

3. The Appellant is [redacted] Medicaid beneficiary [redacted]). The Appellant's diagnoses are attention-deficit/hyperactivity disorder, disruptive behavior disorder, and learning disorder. (Exhibit 3).

4. The Appellant attends school five days a week but does not attend special education classes despite his mother's request of the school for those services. (Exhibit 3, page 1).

5. The Appellant lives with his [redacted]. (Exhibit 3).

6. On [redacted], Appellant's [redacted] met with members of CLS staff for an Individualized Plan of Service (IPOS) planning meeting. (Exhibit 4).

7. The result of Appellant's IPOS meeting was an authorization of case management and supports coordination services, respite services, and fiscal intermediary services as Appellant chose to receive his services through self-determination. (Exhibit 4).

8. At the [redacted] planning meeting, the Appellant's mother requested 20 hours of respite per week. (Exhibit 4).

9. As a result of the [redacted] planning meeting, the CMH reviewed all the services the Appellant was receiving and documentation of his behaviors and needs. The CMH determined that 20 hours of respite services was not medically necessary but five hours of respite services were appropriate. (Exhibit 4).

10. On [redacted], Appellant was sent an Advance Action Notice informing him that his request for an additional 15 hours of respite services from CMH was denied because they were not medically necessary. (Exhibit 1, Page 1). The reason also stated that the current authorization of respite services, "…is sufficient in amount, scope, and duration to reasonably achieve the outcomes identified in the Person-Center-Plan." (Exhibit 1, Page 1). Appellant's notice included a notice of hearing rights. (Exhibit 1, Page 2).

11. The Appellant's request for hearing was received by this office on [redacted]. (Exhibit 2). In the request for hearing the Appellant's [redacted] stated that she was asking for fifteen more hours of respite.

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 [redacted] explained that the Appellant has behavioral issues and is a handful to take care of. The Appellant's [redacted] said that she needs respite services so someone can give her a break from Appellant's behavioral needs. Appellant's [redacted] asserted that if she has more respite hours where someone can take care of Appellant, she can take care of herself and the home, which in turn would make her able to provide better care for the Appellant.

The Appellant's [redacted] testified that she has a psychiatric disorder, schizophrenia, and is trying to care for herself and for her [redacted] as well. The Appellant's [redacted] stated that she does not drive and therefore has to take a bus if she needs to go to her doctor appointment. The Appellant's [redacted] said that it takes a long time for her to get to her doctor appointments because she has to take the bus, and by the time she gets home from a doctor appointment it is already the time Appellant gets home from school. The Appellant's [redacted] gave as an example of how she used respite the week prior to the hearing: the five hours per week of respite she used all at one time on Saturday to get a break from Appellant.

CMH witness [redacted] stated that she was a Master's Degree Social Worker and her role with the CMH contracted agency was to welcome people to mental health services, assess the need for mental health services, as well as help to set goals to be accomplished through the services. [redacted] said that the Appellant's [redacted] stated she was feeling overwhelmed and wanted respite so there would be someone in the home before the Appellant came home from school to help her clean up the home before the Appellant arrived.

[redacted] testified that she explained to the Appellant's [redacted] that respite hours could not be used for someone to come into the home before the Appellant was there to help clean up the home. [redacted] further testified that five hours of respite was approved to give the Appellant's [redacted] a break from the Appellant's behavioral needs. [redacted] explained that 20 hours of respite was not supported because there was no documentation that the additional 15 hours of respite care requested was medically necessary.

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**. (Bold added by ALJ).
>
> *July 1, 2010, Page 110.*

[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. [redacted] explained that she is a supervisor for [redacted] and reviewed the assessment from which [redacted] determined there was medical necessity for five hours of respite per week. The representative for the Community Mental Health, [redacted] and [redacted] explained that the Appellant was receiving other services in the home that needed to be considered, that the Appellant's [redacted] had a break from him five days a week when he was at school, and that all those services combined were considered when determining the adequacy of the authorized respite services hours.

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 not authorizing respite other than to provide temporary relief for the Appellant's [redacted]. Further, the administrative law judge is limited to making a decision based on the information the CMH had at the time it decided to authorize the Appellant's services at five hours of respite per week. The Appellant, who bears the burden of proving by a preponderance of evidence that there was medical necessity for fifteen additional 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 Appellant's CMH-provided services, including respite services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/14/2011

***** 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.