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. 2012-13289 CMH
Case No. 92227179

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], Appellant's mother, [redacted], fiancée, [redacted], respite care giver, and [redacted], case manager, appeared and testified on Appellant's behalf.

[redacted], Manager of Due Process, appeared on behalf of [redacted] County Community Mental Health (CMH or the Department). [redacted], Care Coordinator, Utilization Management, 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). (Exhibit 1, 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 1, p 1). The Appellant is diagnosed with ADHD and ODD and is also cognitively impaired/mildly mentally retarded. (Exhibit 1, p 3).

4. The Appellant lives with her mother and her mother's fiancée. (Exhibit A, p 1; Testimony).

5. Appellant's mother is her primary caregiver and she works full-time. (Exhibit 1, p 3). Appellant's mother has natural supports in the area, but they no longer are able or willing to care for Appellant. (Exhibit 1, p 1; Testimony).

6. Appellant is enrolled in special education at school and is out of the home approximately 6 hours per day Monday - Friday. (Exhibit 1, p 3; Testimony)

7. On [redacted], Appellant's mother requested 64 hours per month of respite. On [redacted], CMH conducted a Respite Assessment. As a result of the Assessment, Appellant's mother was approved for 23 hours of respite per month. (Exhibit 1, pp 1-5)

8. On [redacted], CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the request for 64 respite hours per month was denied, but that 23 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pp 6-8).

9. The Michigan Administrative Hearing System received Appellant's request for hearing 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 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], Care Coordinator in the Utilization Management Department, reviewed Appellant's Respite Assessment and testified that Appellant was awarded 6 respite hours because Appellant has one care giver who works full-time, 2 respite hours because Appellant requires 1-2 or more interventions per night, 1 respite hour because Appellant is verbally abusive on a daily basis, 2 respite hours because Appellant is physically abusive to others on a weekly basis, 2 respite hours because Appellant is

physically abusive to herself on a weekly basis, 2 respite hours because Appellant destroys or disrupts property on a weekly basis, 1 respite hour because Appellant has weekly temper tantrums, and 1 respite hour because Appellant wanders on a weekly basis. [redacted] testified that Appellant was also awarded 2 respite hours because she requires reminding with oral care, 2 respite hours because Appellant can eat independently after setup, and 2 respite hours because Appellant requires reminding with bathing, for a total of 23 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] 1. Under the prior scoring tool, individuals were granted 20 respite hours 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 respite hours up front, but those 20 hours have been redistributed throughout the scoring tool, and are available based on individual need. [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 and that all authorizations for services are based on documentation. [redacted] indicated that it is possible to obtain the maximum of 96 hours of respite hours per month using the scoring tool. [redacted] also 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 23 respite hours approved per month accurately reflects the needs of the Appellant.

[redacted], Appellant's mother testified that Appellant is physically abusive to others on a daily basis and that she wanders more often than weekly, especially during the summer. [redacted] also indicated that Appellant does exhibit inappropriate touching and that Appellant sometimes requires more than 1-2 interventions per night. [redacted] testified that Appellant does have an unsteady gait and that she falls often. [redacted] also indicated that Appellant does sometimes require assistance eating, especially eating the right foods, that Appellant needs help picking out appropriate clothing and that she has difficulty with zippers and buttons.

[redacted] testified that she uses respite hours to visit family, go to the gym and work out, and to do shopping. [redacted] indicated that she has not heard of, or used, community living supports. [redacted] testified that Appellant's doctor is checking her for multiple sclerosis because of her unsteady gate, but that the results of those tests have not been received.

[redacted], [redacted] fiancé, testified that he also lives in the home with Appellant and her mother, and that Appellant does need constant supervision. [redacted] testified that Appellant has fallen down the stairs and outside in his presence.

[redacted], Appellant's respite care worker, testified that she has been working with Appellant for 4-5 years and that Appellant does need constant supervision. [redacted]

[redacted] testified that Appellant wanders a lot, especially during the summer, and that is she is not watching Appellant every minute, Appellant will disappear. [redacted] testified that she sometimes has to knock on doors in the neighborhood to track Appellant down after she disappears.

[redacted] is Appellant's case manager and is the person who interviewed Appellant's mother for the respite assessment. [redacted] testified that Appellant needs constant supervision, that she can be provocative, that she is very impulsive and can easily become angry and upset. With regard to the respite assessment, [redacted] testified that the information contained in the assessment was correct at the time it was done, but that it could be updated.

Following the testimony, [redacted] testified that she and [redacted] now believed Appellant was entitled to 35 respite hours per month, not 23 hours originally authorized.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard 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.
>
> *MPM, Mental Health and Substance Abuse Section, October 1, 2011, Page 118-119*

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 her 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 35

respite hours per month authorized.

The CMH representative further pointed out that the Medicaid Provider Manual requires parents of children with disabilities to provide the same level of care they would provide to their children without disabilities. The CMH representative explained that this meant that public benefits could not be used where it was reasonable to expect the parent would provide care, i.e., if the parent had to purée or cut food into very small pieces to prevent choking, or supervise for safety due to lack of mobility and verbal skills.

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> 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. <u>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.</u> 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. (Emphasis added).
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> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 98*

A review of the Medicaid Provider Manual supports the CMH position that B3 supports and services are not intended to meet all of an individual's needs and that it is reasonable to expect that Appellant's mother would provide care for the period of time proposed by the CMH without use of Medicaid funding.

The Appellant bears the burden of proving by a preponderance of the evidence that the

approved 23 hours of respite per month was inadequate to meet the Appellant's mother's needs. As indicated above, CMH indicated following the testimony that Appellant was actually entitled to 35 hours per month, so Appellant then bears the burden of proving that these 35 hours of respite per month are inadequate. The Appellant's mother did not prove by a preponderance of the evidence that the 35 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 35 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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/19/2012

***** NOTICE *****

The Michigan Administrative Hearings System 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 Michigan Administrative Hearing System 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.