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. 2012-16346 CMH
Case No. 25442741

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 and testified on behalf of the Appellant.

[redacted], Assistant Corporation Counsel, [redacted] County Community Mental Health Authority (CMH), represented the Department. Dr. [redacted], Ph.D., CMH Manager for Clinical Services and Quality Improvement, appeared as a witness for the Department.

ISSUE

Did the CMH properly reduce the 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 receiving services through [redacted] County Community Mental Health (CMH). Appellant is enrolled in Medicaid, but not in any of the specialty Medicaid Waivers. Services are currently delivered through a self determination arrangement. (Exhibit 1 and Attachment C).

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 was an [redacted] year old Medicaid beneficiary at time of hearing, date of birth [redacted]. The Appellant is diagnosed with

Pelizeaus-Merzbacher disease, severe mental retardation, underdeveloped immune system, asthma, and nystagmus. The Appellant is functionally nonverbal and non-ambulatory. (Exhibit 1 and Attachment D).

4. The Appellant lives with his mother and sees his father sporadically. (Exhibit 1 and Attachment D).

5. Appellant's mother is his primary caregiver. (Exhibit 1 and Attachment D).

6. In [redacted], Appellant's supports coordinator asked that an additional 17.5 hours of respite care be added to the 12.5 already authorized due to an injury to Appellant's mother's shoulder. The respite hours were increased to 30 hours per week from [redacted] to [redacted]. On [redacted] a request for 30 hours per week was received for the period from [redacted] through [redacted]. (Exhibit 1 and Attachment H).

7. On [redacted], CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the requested respite care of 30 hours per week were not medically necessary. The Adequate Action Notice indicated the respite hours would be reduced at to 12.5 hours per week. The notice included rights to a Medicaid fair hearing. (Exhibit 1 and Attachment A).

8. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on December 13, 2011. (Exhibit 1 and Attachment B).

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] testified she reviewed all the documents admitted into the record prior to her testimony. [redacted] stated Appellant was [redacted] years old and had diagnoses of severe mental retardation, Pelizeaus-Merzbacher disease, a disease of the nerves causing weakness, underdeveloped immune system, nystagmus, and

asthma. Appellant has been receiving Medicaid services through CMH including respite services, CLS, and supports coordination services. Dr. [redacted] stated Appellant was being home schooled at this time.

Dr. [redacted] stated that according to policy in the Medicaid Provider Manual CMH can only approve respite hours that are medically necessary and respite hours are only to be used for a temporary relief and can not be provided on a continuous long term basis. (See Exhibit 1 and Attachment J). Dr. [redacted] stated Appellant had been authorized for 12.5 respite hours per week, which is the norm for all recipients in [redacted] County. However, in [redacted] through [redacted], Appellant's respite hours were increased to 30 hours per week due to a documented injury to Appellant's mother's shoulder.

On [redacted], after sufficient time had passed for recovery from the documented shoulder injury, the Appellant's respite hours were reduced to the norm of 12.5 per week for the month of [redacted]. CMH had not received any additional documentation to support the continuation of respite hours at the higher level of 30 hours per week. For the current authorization period which runs from [redacted] through [redacted], CMH received a request for 12.5 hours per week of respite care and authorized 12.5 hours per week. CMH believes the request for an increased amount of respite hours for the month of [redacted] is now moot. (Exhibit 1, Attachment H, and testimony).

The Appellant's mother [redacted] testified Appellant was not mentally retarded, that he is physically disabled, his immune system is weak, and he can't speak on a normal level. [redacted] stated she submitted for extra respite hours due to her shoulder and back injuries. She stated she is only 120 pounds and her son is 65 pounds. She stated caring for her son requires a lot of lifting.

[redacted] stated she was not aware that her worker had only requested 12.5 hours of respite care for the new authorization period. She admitted that she had not submitted anything to the CMH regarding her back injury for them to review for a possible increase in her respite hours. She thought her worker would have done this for her, and she stated there has been an obvious break down in communication. [redacted] stated she was only asking for the 30 hours or any additional respite hours that could be approved on a temporary basis until she is able get better.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to B3 supports and services including Respite Care:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid

State Plan Specialty Supports and Services or Habilitation Waiver services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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.

* * *

17.3.J. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid 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.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to

> provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse Section,*
> January 1, 2012 version, pp. 105-106, 118-120.

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 policy contained in the Medicaid Provider Manual demonstrates that CMH properly reduced the respite services to 12.5 hours of respite care for the period from [redacted] to [redacted]. The documentation available to CMH at the time they made their determination to reduce services on [redacted] established that a return to the norm of 12.5 hours of respite care per week was proper. CMH had approved the increased amount of 30 hours per week during the period of time reasonably necessary for Appellant's mother to recover from her shoulder injury. No further documentation was made available to CMH concerning any back injury or anything else which would support continuing the respite hours at the higher level of 30 hours per week.

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. 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. It is reasonable to expect that Appellant's parent would provide care for the remainder of the time, just as they would provide to their children without disabilities without the use of Medicaid funding.

The Appellant bears the burden of proving by a preponderance of the evidence that the 12.5 hours of respite was inadequate to meet the Appellant's mother's needs. Based upon the information available at the time CMH made the decision to reduce the respite care, the decision was proper. The testimony of the Appellant's mother established that there may be new or additional information that was not considered at that time which could arguably result in the authorization of additional respite hours. A further review is still possible to consider such information. However, Appellant's proofs did not meet the burden of establishing medical necessity above and beyond the 12.5 respite hours determined to be medically necessary by CMH in accordance to the Code of Federal Regulations (CFR) on [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's services to 12.5 respite hours per week.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/27/2012

***** NOTICE *****

The Michigan Administrative Hearing 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.