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],

Appellant
_____/

Docket No. 2012-16347 CMH
Case No. 43398202

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], 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 deny the Appellant's request for additional 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. 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. Appellant was a [redacted] year old Medicaid beneficiary at time of hearing, date of birth [redacted]. Appellant is diagnosed as a person with cerebral palsy who has a history of infantile seizure patterns. With medication, Appellant's seizures have been reduced to two spasms per day. (Exhibit 1 and Attachment D).

4. Appellant lives with her mother and great aunt. (Exhibit 1 and Attachment D, page 19).

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

6. Appellant has been receiving services through CMH since [redacted], which have included assessments, treatment planning, and supports coordination. Appellant's mother has received respite services. Services are delivered through a self-determination arrangement. (Exhibit 1).

7. From [redacted] the CMH authorized 12.5 hours of respite per week for Appellant's mother. (Exhibit 1 and Attachment F).

8. On [redacted], a PCP Progress Review indicated that Appellant's mother recently tore her LCL and was requesting an additional 57.5 hours of respite care for the time period [redacted]. (Exhibit 1 and Attachments E & F).

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant notifying her that the additional 57.5 respite hours per week that were requested for the time period from [redacted] through [redacted] were not medically necessary. The CMH mailed an Adequate Action Notice indicating the respite hours would remain at 12.5 per week. The notice included rights to a Medicaid fair hearing. (Exhibit 1 and Attachment A).

10. The Michigan Administrative Hearings System received Appellant's request for hearing on [redacted]. (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 Dr. [redacted] testified she has a doctorate in psychology and is a fully licensed psychologist in Michigan. She stated Appellant was a [redacted] year old ([redacted]), diagnosed with cerebral palsy and a history of infantile seizure patterns. Dr. [redacted] stated Appellant attends the [redacted] Intermediate Schools two times per week.

Appellant's mother requested authorization for an additional 57.5 hours per week of respite care, i.e., from 9 a.m. to 7 p.m. daily for the period [redacted] through [redacted].

Dr. [redacted] stated Appellant's request for respite care from 9 a.m. to 7 p.m. daily was not reasonable. In [redacted] County the norm is 12.5 hours per week. Dr. [redacted] stated in her professional opinion the additional 57.5 hours requested were not medically necessary and that 12.5 hours were sufficient to meet the needs of the Appellant's mother.

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 I). Dr. [redacted] further stated 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. Since Appellant was a two year old, such children do require 24 hour care, and parents can normally be expected to provide such care for their minor children. (See Exhibit 1 and Attachment H).

Dr. [redacted] pointed out that for the current authorization period of [redacted] through [redacted], Appellant requested only 12.5 hours of respite care and 12.5 hours were approved. CMH believes that the request for the additional 57.5 hours is now moot.

The Appellant's mother testified she has obtained additional documentation concerning her daughter's condition and her own condition caused by Appellant's change in sleep patterns and increased seizure activity. (Exhibits 2-5). [redacted] acknowledged that none of this additional information had been provided to CMH for them to consider in connection with her request for additional respite hours. [redacted] stated Appellant had several workers through TTI and they have not facilitated her requests for additional respite hours. [redacted] indicated she would like a new evaluation based on this additional documentation.

Dr. [redacted] responded that CMH could do a review of this new information and do an evaluation of the need for additional respite hours. Dr. [redacted] stated [redacted] would be put in touch with the [redacted] that day to obtain a review of the additional documentation provided at the hearing. Dr. [redacted] further noted that the dates on these new documents are after the date the decision was made in this case to deny Appellant's request for additional respite hours.

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 her goals.

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 family would provide care for the period of time proposed by the CMH without use of Medicaid funding.

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 in not authorizing respite other than to provide temporary relief for the Appellant's mother. 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 12.5 hours of respite per week.

The Appellant bears the burden of proving by a preponderance of the evidence that at the time CMH denied the request for additional respite hours there was documentation showing that the 12.5 hours of respite care was inadequate to meet the Appellant's mother's needs. The testimony by Appellant's mother did not show that there was medical necessity above and beyond the 12.5 respite hours determined to be medically necessary by CMH in accordance with the Code of Federal Regulations (CFR) on December 5, 2011.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH acted properly to properly deny the Appellant's request for additional respite hours.

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

[redacted]
Docket No. 2012-16347 CMH
Decision and Order

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.