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. 2012-27930 CMH
Case No. [redacted]

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 [redacted] Appellant's guardian and grandmother appeared and testified on Appellant's behalf.

[redacted], Manager of Due Process, appeared on behalf of [redacted] (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] (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 mental retardation, severity unspecified. He also has numerous health problems, including mitochondrial myopathy uncoupled, restrictive lung disease, brain atrophy, scoliosis, developmental delay, and asthma.

Tracheotomy was placed in [redacted] due to upper airway collapsing. (Exhibit 1, p 3).

4. The Appellant lives with his grandparents. (Exhibit 1, p 1; Testimony).

5. Appellant's grandmother is his primary caregiver and she does not work. Appellant's grandfather is also in the home, but he works long hours and is unable to provide much assistance in the home. (Exhibit 1, p 3). Appellant's grandmother also has back problems and requires surgery, but cannot have the surgery unless she is no longer doing the more difficult things with [redacted], such as lifting him. (Exhibit 1, p 3).

6. Appellant attends the [redacted] 3.5 days per week from 8:00 a.m. to 3:15 p.m.; however, Appellant's grandmother testified that he misses a lot of school because of his health problems. (Exhibit 1, p 3; Testimony)

7. On [redacted], Appellant's grandmother requested 96 hours per month of respite. On [redacted], CMH conducted a Respite Assessment. As a result of the Assessment, Appellant's grandmother was approved for 39 hours of respite per month. (Exhibit 1, pp 1-5)

8. On [redacted], CMH sent an Adequate Action Notice to the Appellant's grandmother notifying her that the request for 96 respite hours per month was denied, but that 39 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pp 6-8).

9. On [redacted], Appellant's grandmother requested 80 hours per month of respite. On [redacted], CMH conducted a Respite Assessment. As a result of the Assessment, Appellant's grandmother was approved for 41 hours of respite per month. (Exhibit 1, pp 26-30)

10. On [redacted], CMH sent an Adequate Action Notice to the Appellant's grandmother notifying her that the request for 80 respite hours per month was denied, but that 41 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pp 31-33).

11. 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 [redacted] Respite Assessment and testified that Appellant was awarded 2 respite hours because Appellant has two care-givers, one of whom works full-time, 2 respite hours because Appellant's primary care giver has a condition that interferes with the provision of care, 4 respite hours because Appellant requires 3 or more interventions per night, and 1 respite hour because Appellant has weekly temper tantrums. [redacted] testified that Appellant was also awarded 4 respite hours because he requires total physical assistance with mobility, 4 respite hours because Appellant requires total physical assistance with oral care, 4 respite hours because Appellant requires total physical assistance with eating, 4 respite hours because Appellant requires total physical assistance with bathing, 4 respite hours because Appellant requires total physical assistance with toileting, and 4 respite hours because Appellant requires total physical assistance with dressing. [redacted] testified that Appellant was also awarded 4 respite hours because he requires total physical assistance with grooming, 4 respite hours for other clinical needs (including medical care and repositioning), and 6 respite hours awarded under the section titled "Additional Supporting Details and Comments". (See Exhibit 1, p 28). Adding up the total respite hours testified to by [redacted] indicates that Appellant is entitled to 47 respite hours per month, not 41 hours as indicated in the Notice and Hearing Rights.

[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 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] 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 41 respite hours approved per month accurately reflects the needs of the Appellant.

[redacted], Appellant's grandmother, testified that while Appellant is tube fed at night, he does eat regular food during the day. [redacted] explained that her main problem currently is that Appellant has been approved for nursing care since his

tracheotomy, but that the nurses are all female and do not know sign language. Because Appellant is 14 years old, he is not comfortable being changed by a female nurse, and the communication board he is provided is useless for communication purposes during an emergency. On the other hand, Appellant's grandmother pointed out that Appellant's respite worker does know sign language and, because she has been working with Appellant for many years, he is comfortable with her changing him. [redacted] also indicated that the nursing staff has to be in the home for 6, 8, or 10 hour increments and that Appellant does not need care for that many hours in a row. As a result, the nursing staff ends up sitting around doing paperwork or watching television. [redacted] testified that it would make more sense, and be less expensive for the State, if Appellant were allowed more respite hours and less nursing hours.

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, January 1, 2012, Pages 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 and the testimony shows that Appellant is entitled to 47 respite hours per month, not the 41 respite hours per month as indicated in the Notice and Hearing Rights. However, the evidence does not support Appellant's request for either 96 or 80 respite hours per month.

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, January 1, 2012, Page 106*

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 41 hours of respite per month was inadequate to meet the Appellant's

mother's needs. As indicated above, [redacted] testified that Appellant is actually entitled to 47 respite hours per month, not the 41 respite hours per month as indicated in the Notice and Hearing Rights. As such, Appellant then bears the burden of proving that these 47 hours of respite per month are inadequate. The Appellant's grandmother did not prove by a preponderance of the evidence that the 47 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. Further, while it may make sense to award Appellant more respite hours than nursing hours, the two authorizations are ultimately unrelated. Respite hours are determined by the CMH pursuant to the aforementioned respite assessments while nursing hours are awarded using different criteria by a different governmental agency.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that 47 respite hours per month are appropriate.

IT IS THEREFORE ORDERED that:

The CMH decision is MODIFIED. The Appellant is entitled to 47 respite hours per month, not 41 respite hours per month as indicated in the Notice and Hearing Rights.

Robert J. Meade
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/7/2012

***** 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.