STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted][1]

Docket No. 2012-59054 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the Appellant's request for a hearing.

After due notice, a hearing held on [redacted] Appellant's father, appeared and testified on Appellant's behalf. [redacted], Assistant Corporation Counsel, represented the Macomb County Community Mental Health Authority (CMH). [redacted] CMH Access Center Manager, appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for 50 additional respite care hours per month?

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 an [redacted] who has been diagnosed with Down's Syndrome, Intractable Epilepsy, and Congenital Heart Syndrome (Exhibit 1, pages 17, 19).

2. The 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 has been receiving Medicaid covered services through the CMH since 2006 and her services have included assessments, supports coordination, treatment planning, physical therapy, occupational therapy,

[1] The request for hearing incorrectly identified [redacted] Appellant's mother, as the named appellant. However, while the request relates to Appellant's mother, [redacted] is the beneficiary in this case and the proper named appellant.
[2] Appellant's father does not speak English and used an interpreter.

speech and language therapy, respite care and community living supports (CLS). (Testimony of [redacted] .

4. Specifically, Appellant had been receiving 21 hours a week of CLS and 50 hours of respite care per month. (Testimony of [redacted]).

5. In [redacted] Appellant's family requested an additional 50 hours of respite care per month. The request was based on the fact that Appellant's mother had recently been diagnosed with leukemia and would not be able to care for Appellant at the same level while undergoing treatment. (Exhibit 1, page 10; Testimony of Appellant's father).

6. On [redacted] the CMH sent a notice to Appellant notifying her that the request for increased respite care had been denied. The stated reason for the denial was that "[s]ervices currently authorized are sufficient to meet consumer goals." (Exhibit 1, page 7).

7. The Michigan Administrative Hearing System (MAHS) received a request for hearing filed on behalf of Appellant on [redacted] (Exhibit 1, page 13).

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… [42 USC 1396n(b).]

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.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section, articulates the relevant policy and, with respect to respite care services, it states:

> **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).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)

- Home of a friend or relative chosen by the beneficiary and members of the planning team

- Licensed camp

- In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MRs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. [MPM, Mental Health and Substance Abuse Section, April 1, 2012, pages 118-120.]

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230. Regarding medical necessity, the MPM provides:

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity. [MPM, Mental Health and Substance Abuse Section, April 1, 2012, pages 12-13.]

The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits as medically necessary:

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- Documented in the individual plan of service. [MPM, Mental Health and Substance Abuse Section, April 1, 2012, page 13.]

In addition to requiring medical necessity, the MPM also states that B3 supports and services, such as respite care services, are 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. 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. [MPM, Mental Health and Substance Abuse Section, April 1, 2012, page 106.]

Here, the request for increased respite was based on the fact that Appellant's mother had been diagnosed with leukemia and would not be able to care for Appellant at the same level while undergoing treatment.

The CMH agrees that Appellant's family's reason for requesting more respite is legitimate, but it also asserts that it cannot simply rely on statements made by the family and that a temporary condition or change in circumstances does not justify a general increase. Instead, in order to determine that a temporary increase was medically

necessary, the CMH would need to more information and documentation regarding Appellant's mother's treatment. Information and documentation regarding details such as the time span of the treatment, the specific dates of procedures and the effects of the procedures would allow the CMH to authorize the increased respite on a limited basis. As testified to by [redacted] Appellant had not provided such information at the time the denial was made.

Appellant's father asserts that he did provide such information, but he did not produce any documents at the hearing. The record was also left open so that Appellant's father could submit additional evidence and he provided an [redacted] letter from a Dr. [redacted] (Exhibit 2). That letter stated that Appellant's mother had been diagnosed with leukemia and would be undergoing treatment for at least six months. (Exhibit 2, page 1).

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred. Here, this Administrative Law Judge finds that Appellant failed to meet that burden. [redacted] accurately described the information the CMH needed to find that there was a medical necessity for a temporary increase in respite and she credibly testified that no such information was provided at the time of the denial. Moreover, while Appellant did produce a letter following the hearing, that letter merely stated the diagnosis and suspected length of treatment. Accordingly, it failed to provide sufficient specific information regarding the treatment and its effect on Appellant's care. To the extent that Appellant has additional information to provide, she can always request additional respite at any time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request for an increased amount of respite care.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/01/2012

***** 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.