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. 2012-6270 CMH
Case No. 85797359

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 Tuesday, [redacted]. [redacted], Appellant's mother, appeared on behalf of the Appellant. Appellant, [redacted] was also present but did not provide any testimony.

[redacted], Due Process Manager, appeared on behalf of [redacted] County Community Mental Health (CMH or Department). [redacted], Manager, Utilization Management Department, appeared as a witness for the Department.

ISSUE

Did 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) since [redacted]. (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 an [redacted] year old Medicaid beneficiary whose date of birth is [redacted]. (Exhibit 1, p 1). The Appellant is diagnosed with Bi-

Polar Disorder, NOS; Moderate Mental Retardation, and ADHD. (Testimony). At the time of the assessment, Appellant's medications included Abilify 20mg, Concerta 54 mg, and Vyvanse 60 mg. (Exhibit 1, p 3). Recently, Appellant began taking Seroquil 150 mg. (Testimony)

4. The Appellant lives with his mother and sisters. (Exhibit 1, p 2). Appellant's sister [redacted] is receiving 80 hours of respite per month and his sister [redacted] is receiving 68 hours of respite per month. (Exhibit 1, p 2)

5. Appellant's mother is his primary caregiver. She does not work and is not a student, but she suffers from high blood pressure and depression, which interferes with her ability to provide Appellant care. (Exhibit 1, p 3). Appellant's mother has no other natural supports in the area. (Exhibit 1, p 2).

6. Appellant is enrolled at [redacted] High school, where he is in special education. Due to his behaviors, he only attends school from 12:30 pm to 3:30 pm, Monday through Friday. (Exhibit 1, p 3)

7. On [redacted], Appellant's mother requested 82 respite hours per month. On [redacted], CMH conducted a Respite Assessment. As a result of the Assessment, Appellant was approved for 34 hours of respite per month. (Exhibit 1, pp 1-5).

8. On [redacted], CMH sent an Adequate Action Notice to the Appellant notifying him that the request for 82 respite hours per month was denied, but that 34 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pp 6-8). During the preparation for the hearing, a calculation error was found and the authorization was changed to 38 respite hours per month, effective [redacted]. (Testimony)

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.
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> *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.
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> *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], Manager of the Utilization Management Department, reviewed Appellant's Respite Assessment and testified that Appellant was awarded 4 respite hours because Appellant has one care giver who neither works nor is in school full-time or part-time, 2 respite hours because Appellant's care giver has a condition that interferes with the provision of care, 4 respite hours because Appellant required 3 or more interventions per night, 1 respite hour because Appellant is verbally abusive on a weekly basis, 2 respite hours because Appellant is physically abusive to others on a weekly basis, 2 respite hours because Appellant causes property damage on a weekly basis, 1 respite hour because Appellant has weekly temper tantrums, and 2 respite hours because Appellant wanders on a daily basis. [redacted] testified that Appellant was also awarded 2 respite hours because he requires reminding with oral care, 2 respite hours because Appellant can eat independently after setup, 2 respite hours because Appellant requires reminding with bathing, 2 respite hours because Appellant requires reminding with toileting and 2 respite hours because Appellant requires reminding with dressing. Appellant was also awarded 4 respite hours because he requires total physical assistance with grooming, 3 respite hours because Appellant needs medication administration and is over age 18, and 3 respite hours because Appellant requires extensive prompting and encouragement to participate in tasks. [redacted] testified that the total respite hours found to be medically necessary according to the assessment was 38 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]. 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. [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. [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 his professional opinion, the 38 respite hours approved per month accurately reflects the needs of the Appellant.

Appellant's mother testified that she disagreed with the entire respite assessment, but she could not point to specific areas in the assessment with which she disagreed, nor could she say that the information given to the assessor at the time of the assessment was incorrect. Appellant's mother indicated that Appellant needs constant supervision and that 38 respite hours per month is simply not enough. Appellant's mother indicated that Appellant is only allowed in school for half days now because of his bad behavior and even then he often leaves school, wanders about, smokes marijuana and drinks. Appellant's mother indicated that she actually had to track down her son for the hearing. Appellant's mother also testified that she has never heard of community living supports.

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.
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> *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 his goals.

Applying the facts of this case to the documentation in the respite assessment supports the CMH position that the Appellant's respite needs could be met with the 38 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. 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.
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> *MPM, Mental Health and Substance Abuse Section, October 1, 2011, Page 105*

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 38 hours of respite per month was inadequate to meet the Appellant's needs. The Appellant did not prove by a preponderance of the evidence that the 38 respite hours per month determined to be medically necessary by CMH in accordance to the Code of Federal Regulations (CFR) was inadequate to meet his needs. The Appellant's assertion that the case manager did not have sufficient information at the time it completed the respite assessment is not enough to overcome this burden. If new information comes to light, the Appellant can always request another assessment. 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 38 respite hours per month approved for Appellant are appropriate.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/7/2011

***** 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.