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) 373-4147

IN THE MATTER OF:

Docket No. 2013-50382 CMH

[redacted], [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] [redacted] mother and Guardian, represented the Appellant.

[redacted], Director of Administrative Services and Hearings Officer, represented [redacted] County Community Mental Health Authority (CMH or Department). [redacted], [redacted], Supervisor of Case Managers, and [redacted] PIHP Care Management Director, appeared as witnesses for the Department.

ISSUE

Did the CMH properly determine 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 [redacted]-year-old male who has been diagnosed with mental retardation, cerebral palsy, and hearing loss. (Exhibit 3, page 1)

2. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the applicable service area.

3. The Appellant currently lives at home with his parents and attends the [redacted] in [redacted] County. (Exhibit 3, page 2; Mother Testimony)

4. The Appellant attends church, is involved in 4-H, and rides weekly with the [redacted]. (Exhibit 3, page 2; Supervisor of Case Managers Testimony)

5. The Appellant needs assistance in daily living skill areas, with his medical care needs, and in all health and safety areas. Once the Appellant turned [redacted] years old, his family applied for and is receiving SSI and Home Help Services. (Exhibit 3, page 2; Supervisor of Case Managers Testimony)

6. About a year ago, the Appellant moved from [redacted] County to rural [redacted] out in the county. (Exhibit 3, page 2; Supervisor of Case Managers Testimony)

7. The Appellant had been receiving [redacted] hours per month of Respite services, which was authorized during the transition when the Appellant first moved from [redacted] County, was not settled in, and the CMH was unsure of his schedule and natural supports. (Exhibit 3, page 2; Supervisor of Case Managers Testimony)

8. On [redacted], an Individual Plan of Service meeting was held and it was determined that the Appellant's Respite hours should be reduced to [redacted] hours per month. (Exhibit 3; Supervisor of Case Managers Testimony)

9. On [redacted], CMH sent the Appellant an Adequate Action Notice notifying him that the individual Plan/Amendment/Periodic Review defines the amount, duration and scope of the services that are authorized and that services will start within [redacted] calendar days from the agreed upon start date. The Notice also contained the Appellant's rights to a Medicaid fair hearing. (Exhibit 4)

10. On [redacted] the Michigan Administrative Hearing System (MAHS) received the Appellant's request for hearing request.

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. The 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.*

With respect to medical necessity, the Medicaid Provider Manual states:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

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.

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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

Medicaid Provider Manual
Mental Health and Substance Abuse Section,
April 1, 2013, Pages 12-13

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

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).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

> 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.
>
> *MPM, Mental Health and Substance Abuse Section, April 1, 2013, Page 124*

The Medicaid Provider Manual also explicitly states that B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need:

> 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, April 1, 2013, Page 111*

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.

In this case the initial authorization of [redacted] hours of Respite per month was made during the transition when the Appellant first moved from [redacted] County, was not settled in, and the CMH was unsure of his schedule and natural supports. For the [redacted] Individual Plan of Service, the Appellant had settled in and things were in place. Further, the Appellant's mother is now the paid caregiver for the Home Help Services for the Appellant. The CMH determined that [redacted] hours of Respite per month was sufficient to meet the Appellant's medically necessary needs. (Exhibits 1-5; Supervisor of Case Managers Testimony; PIHP Care Management Director Testimony)

The Appellant's mother disagrees with the reduction to the Respite hours and clarified that the Home Help Services are provided all day long, as opposed to in the limited blocks of time shown on the CMH schedule for the Appellant. The Appellant only has half days of school on [redacted], and the school hours are further shortened during the summer program. When he is not at school, the Appellant has to have supervision at all times with anything he does. For example the Appellant is not dropped off and left alone for his riding lessons. Further, it is hard to find anyone willing to work for just a few hours at a time to provide the respite services and give the Appellant's parents a break. The Appellant's sisters have busy schedules, and one of them now lives an hour away. It is not easy to find a babysitter for an adult and when potential workers were interviewed, they wanted [redacted] hour blocks. It is not worth it for someone to come to work for only [redacted] hours at a time. Caring for the Appellant is emotionally and physically draining. The Appellant's mother is frustrated because as the Appellant gets older caring for him has gotten harder, yet the hours are being cut. (Mother Testimony)

The Supervisor of Case Managers explained that because respite cannot be authorized during times a caregiver is paid to provide care, the Home Help Services hours have to be reflected in the weekly schedule. While it is clear that some help with ADLs will occur outside the time blocks scheduled for Home Help Services, the CMH does have to consider that paid care time and attempted to place it on the weekly schedule in the time blocks that they believed most of that care is provided during. (Supervisor of Case Managers Testimony)

The evidence supports the CMH's determination to authorize [redacted] respite hours per month. The Appellant bears the burden of proving by a preponderance of the evidence that the approved [redacted] hours of respite per month was inadequate to meet the medically necessary need for respite. The Appellant's mother did not meet this burden. This ALJ does not doubt that the Appellant has needs for significant amounts of assistance from his parents, the primary caregivers. Respite hours are intended to be provided on 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. The greater Respite authorization was appropriate during the transition from the move when there was uncertainty about the Appellant's schedule and natural supports. However, now there has now been time to settle in and things are in place. The Appellant attends school four and a half days per week most of the year. Additionally, the Appellant's

mother is now the paid caregiver for the Home Help Services for the Appellant. Additional Respite hours cannot be authorized to provide a break from paid care. The reduction to [redacted] hours per week of Respite services should be sufficient to meet the medically necessary need. The available information supports the CMH determination to reduce the Appellant's Respite authorization.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] respite hours per month is appropriate.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

_____
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

***** 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.