STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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. 2009-13563 CMH
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Authorized Representative, appeared on behalf of [redacted] (Appellant).

[redacted], appeared on behalf of [redacted] an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded specialty mental health supports and services (hereafter, 'Department').

ISSUE

Has the Department properly terminated the Appellant's respite services?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is an adult Medicaid beneficiary who is receiving Medicaid-funded specialty mental health services and supports through [redacted].

2. On [redacted] the Appellant was issued an Advance Negative Action Notice informing her that respite services would be terminated, effective [redacted]. The action was taken after [redacted] discovered that the Appellant resides with her mother, who is a paid chore provider through the Department of Human Services, Adult Home Help Services Program.

3. The Appellant attends school five days per week, between the hours of [redacted] The Appellant's mother, [redacted], is paid to provide 90 hours per month of adult home help services. Additionally, the Appellant receives community living supports (CLS) through [redacted] that vary from 38 hours per week when she is in school, to 70 hours per week when not attending school.

4. On [redacted], the Appellant filed a Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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. [redacted] 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.*

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearings and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

It is undisputed the Appellant's remains eligibile for services. At issue is the Appellant's eligibility for Respite services, given that her mother is a paid provider under the Department of Human Services Adult Home Help Services Program.

Current respite policy provides for temporary relief to the unpaid primary caregiver. The *Medicaid Provider Manual, Mental Health/Substance Abuse, January 1, 2009, Pages 106 and 107,* states:

> **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.
>
> 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.
>
> ***Michigan Department of Community Health***
> ***Medicaid Provider Manual***
> ***Mental Health and Substance Abuse Services***
> ***Version Date: January 1, 2009***
> ***pp. 106-107***

Current interpretation of respite eligibility policy, however, does not support the action taken by the [redacted].

The following factual scenario mirrors the facts of this case, and, under current interpretation, would qualify for respite coverage, albeit on a limited basis.

> *A Medicaid beneficiary resides with a relative in her home. The beneficiary's relative is paid to provide care 40 hours per week, based on a 7-day week, under the Department of Human Services Adult Home Help Services Program. Thus, the relative is paid to provide care for approximately 5-6 hours per day. The beneficiary also attends school or a day programs for five hours per day, four days a week, for a total of 20 hours per week.*

The evidence presented and undisputed establishes the Appellant currently resides with her mother, that her mother is also her paid primary care giver under the Adult Home Help Services Program, and that her mother is paid to provide CLS. The evidence presented and also undisputed establishes that the Appellant attends school five days a week between the hours of [redacted]

However, under current interpretation of respite policy, the issue of whether the primary caregiver is paid to provide services is not a defining factor in whether respite may be awarded.

The Appellant's mother credibly testified that, although she is paid to provide care during certain hours of each day, she also provides uncompensated care on a daily basis. Respite is intended to provide the unpaid primary caregiver a break from care, and can be used to fund care for a beneficiary during times in which the primary caregiver is not being paid to provide care. (Emphasis supplied by ALJ)

Here, the evidence presented supports a conclusion that the Appellant's mother is unpaid to provide care during some portions of each day. Thus, respite eligibility has been satisfied.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that [redacted] improperly terminated the Appellant's respite services.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/27/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.