STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],
Appellant

_____/

Docket No. 2009-16003 CMH
Case No. [redacted]
Load No. [redacted]

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], appeared on behalf of the Appellant. Her witnesses were; [redacted]. [redacted], represented the CMH.

PRELIMINARY MATTER

The only issue in dispute is the Appellant's receipt of Respite services.

ISSUE

Did the Department properly terminate the Appellant's Respite supports?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of hearing the Appellant is a [redacted] male Medicaid, SSI beneficiary. He is not enrolled in the HAB waiver. (Appellant's Exhibit #1)

2. The Appellant has been identified as a person with Developmental Disability – a diagnosis which not disputed. (Appellant's Exhibit # 1, p. 4 and See Testimony of [redacted])

3. The Appellant has epilepsy (uncontrolled), seizure disorder and liver failure stage 1. (See Testimony of [redacted])

4. The Appellant receives hands-on Home Help Services from DHS through ARC in the amount of 4-hours every day. (See Testimony and Department's Exhibit A, p. 1)

5. The Appellant receives 250 hours of CLS and 8 units of Supports Coordination and in 156 hours of skill building per year. The disputed Respite allowance was slated at 38 hours per month. (See Testimony of [redacted] and Department's Exhibit A, pp. 1 and 17)

6. The Appellant has a Person-Centered Plan. (Appellant's Exhibit #1, p. 8, attachment 4)

7. The Appellant and his mother/guardian are the only residents at [redacted]. (See Testimony of [redacted])

8. The Department terminated Respite because the Appellant's guardian was a paid provider via HHS/DHS payment. (Department's Exhibit A, p. 1)

9. The Appellant's witnesses stated that the Appellant has daily seizures and requires around the clock supervision. (See Testimony and Appellant's Exhibit #1 – throughout)

10. On [redacted] the Appellant and his guardian were advised of the termination of services. They were also advised of his further appeal rights. (Department's Exhibit A, p. 1 and Appellant's Exhibit #1, p. 2 and attachment 2 page 5)

11. The instant request for hearing on behalf of the Appellant was received by SOAHR on [redacted]. (Appellant's Exhibit #1 and Department's Exhibit A, p. 1)

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.
>
> 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) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The [redacted] (the Department) contracts with the Michigan Department of Community Health to provide services under the HSW.

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the

authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals [ ] and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. . . .

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

> 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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> * * *
>
> **Respite**
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> In this case, the Appellant's representative sought reinstatement of Respite supports following the Department's decision to terminate Respite owing to the care provider's DHS/HHS reimbursed status. The Appellant's representative and witness explained that Respite services were a vital component of the necessary mix of services which enable the Appellant to stay at home - in the community- with his family
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> The Code of Federal Regulations provides that 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.

To determine what is considered under Medicaid covered Respite services we look to the definition of Respite in the Medicaid Provider Manual, Mental Health [ ] April 1, 2009, page 106:

> **17.3.J. RESPITE CARE SERVICES**
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> 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. (Emphasis supplied) *Supra* MPM §17.3.J.

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The Department witness, [redacted], testified that the decision to terminate Respite was based on their most recent interpretation of guidelines prohibiting Respite payment to

paid providers. There were no other issues in dispute today – including medical necessity. [1] See Appellant's Exhibit and Department's Exhibit - throughout.

On review, it was clear that the Appellant was provided with a reasonable mix of medically necessary services as represented in his person-centered planning. That his care provider is reimbursed for services at 4-hours per day by DHS/HHS is not a barrier to receipt of Respite services for those remaining non-reimbursed hours i.e., when she is working for free. [2]

While the Department acts within its statutory and regulatory authority in placing limits on medically necessary services it is axiomatic that those services are not unlimited but subject to reasonable oversight. In this instance, however, Respite remains justified and properly placed – because of the Appellant's undisputed eligibility, medical necessity and person-centered planning. 42 CFR 440.230 (d)

There is no requirement under Medicaid that the CMH deliver an hourly offset for DHS/HHS reimbursed care providers. In fact almost the opposite is required from those who administer these public funds as they are required to account for their services in light of their particular community of need. They must provide benefits and services in the appropriate amount, scope and duration – all subject to the measurement of medical necessity. *See generally*, MPM §17.2 *Supra*

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly proposed termination of the Appellant's Respite services.

IT IS THEREFORE ORDERED that

The Department's decision is REVERSED.

_____
Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[1] *See* MPM, Mental Health [ ] §2.5 Medical Necessity, p. 12 April 1, 2009.
[2] If the care provider wants a break during her unpaid hours Respite may be used. If she wants a break during the time she provides HHS – then a substitute HHS worker must provide the care.

[redacted]
Docket No. 2009-16003
Hearing Decision & Order

cc: [redacted]

Date Mailed: 6/3/2009

***** 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 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.