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. 2009-32978 CMH
Case 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 [redacted]. [redacted] appeared on behalf of the Appellant. [redacted], appeared on behalf of [redacted]. [redacted] appeared as a witness. [redacted] also appeared as a witness.

ISSUE

Did [redacted] properly authorize respite hours for Appellant?

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 receiving services through [redacted], an [redacted] contractor, as an adult with a Developmental Disability. She is not enrolled in the Habilitation and Supports Waver Program.

2. [redacted] 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 a [redacted] Medicaid beneficiary who attends school. The Appellant is diagnosed as severely multiply impaired, suffering severe physical and cognitive impairments. She resides with her family in the family

home. (uncontested)

4. The Appellant's mother is her guardian and primary care taker. The Appellant's mother is a paid care provider through the Department of Human Services Home Help Services program.

5. The Appellant's mother works full time outside the home.

6. The Appellant's father works full time and must travel away from the home for business and other matters on occasion.

7. The Appellant has been receiving respite services from CMH. She is approved for 6 hours per week respite, as well as 70 overnight respite units per year.

8. The Appellant's mother requested an increase in respite overnight stays (18 additional), to be used during the months of [redacted].

9. The Appellant's mother sought the increase in respite overnight to compensate for increased use of respite during the summer months when she worked nights and taught summer school.

10. [redacted] denied the request for an increase in respite care, sending Notice [redacted].

11. The Appellant requested a hearing [redacted].

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.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section sets forth Medicaid policy for Michigan. Its states with regard to 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 care giver. 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
- 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.

(Underline emphasis added by Administrative Law Judge. Copies of this MPM provision included by CMH as Exhibit E for all Appellants).

Medical Necessity

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/Substance Abuse, October 1, 2007, Pages 12-14,*

The Appellant has the burden of establishing the amount of respite authorized by [redacted] is insufficient in amount, scope and duration to reasonably achieve its stated purpose and that an additional 18 overnight respite stays are medically necessary. The uncontested testimony regarding the need for additional respite care is that the Appellant's mother teaches full time, taught summer school and night school as well. She used the authorized units of respite earlier than expected due to the combined effect of the Appellant's father traveling away from home and her work schedule. She requires additional respite hours to accommodate her continuing work schedule until the next scheduled IPOS. Furthermore, the respite would benefit the Appellant in that she is preparing to live away from home and the increased overnight respite would aid in preparing her for that transition.

The Department's witness asserts an increase in the supports is appropriate, however, not increased respite hours. Additional Community Livings Supports (CLS) hours were offered to address the Appellant's medically necessary needs, however, they were refused. It was asserted that aid in transitioning is not an appropriate use of respite hours, however it is appropriate for CLS.

This Administrative Law Judge agrees with the Department. There is no showing that it is medically necessary to increase the respite authorization for the remainder of the year in this instance. The stated reasons do not establish the amount, scope and duration of the respite hours authorized were insufficient to meet the Appellant's needs. The offer for increased CLS units is appropriate to meet the needs of the Appellant and addresses the stated concerns of her mother.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that [redacted] properly denied the request for increased respite hours.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/15/2009

***** 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.