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

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IN THE MATTER OF:

Appellant
______________________/

Docket No. 2009-4946 CMH
Case No.
Load No.

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 . appeared as Authorized Representative for (Appellant).

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

ISSUE

Has the Department properly terminated Appellant's Respite Care Services?

FINDINGS OF FACT

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

1. The Appellant is a year old Habilitation and Supports Waiver Medicaid beneficiary who is currently being provided Medicaid-funded specialty mental health supports and services through contractor for persons with developmental disabilities. He resides in a shared living arrangement with his caregiver, , and her family in .

2. The Appellant receives Community Living Supports (CLS) paid at a per diem rate for 365 days per year, along with Adult Home Help (AHH) services of approximately 9 hours per week. The Appellant's caregiver, [redacted], is the provider for both CLS and AHH.

3. The Appellant does not attend school, but works daily at a local [redacted] on a volunteer basis via a [redacted] day program.

4. During the Appellant's Person Centered Planning meeting of [redacted], a discussion occurred regarding a continuation of the respite program he has been attending for many years. The program consists of what is known as an [redacted] program 12 days per year. A decision was made during the meeting that the [redacted] program would be terminated, because Respite, by policy, can only be paid to the unpaid, primary caregiver or to paid primary caregivers during portions of the day when they are not being paid to provide care. [redacted] concluded that, because the Appellant's caregiver is paid on a per diem basis, there are no unpaid portions of any particular day.

5. The Appellant was provided notice of the denial on [redacted]. *(Exhibit 1, p. 16)*

6. On [redacted], the Appellant, by and through his caregiver as his Authorized Representative, filed his 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.

The Appellant is enrolled in the HSW. There is no dispute regarding the continuing eligibility for HSW services. At issue is whether the Appellant's current caregiver, paid on a per diem basis for 365 days per year, is eligible to be reimbursed separately for Respite services during times when the Appellant is away from the residence and participating in the [redacted] program.

Respite Services are HSW Medicaid covered services. The Medicaid Provider Manual, Mental Health and Substance Abuse Services chapter provides the HSW Respite Service description.

Section 15.1 Waiver Supports and Services provides, in pertinent part, as follows:

> *Respite is intended for beneficiaries whose primary caregivers typically are the same people day after day (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. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. (Emphasis supplied by ALJ)*
>
> Services must only be provided on a short-term basis because of the need for relief of those persons normally providing the care of a waiver beneficiary during times when they are not being paid to provide care. "Short-term" means the respite service is provided during a limited period of time, for example, a few hours, a few

days, weekends, or for vacations. 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 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 are decided during the person-centered planning process.

Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
  - Group home; or
  - Licensed respite care facility.
  - Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

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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 [redacted] representative testified the Appellant's chore provider is paid a per diem rate to provide both CLS and AHH for 365 days a year. Thus, the per diem rate also compensates the Appellant's caregiver for times she is not providing direct care and/or assistance (while he is participating in his day program). The per diem rate also supports a reasonable conclusion the Appellant's caregiver is never "unpaid" for providing the Appellant with hands-on care and supervision. Any issues regarding the "rate" at which the caregiver is paid is not one over which

the State Office of Administrative Hearings and Rules for the Department of Community Health has jurisdiction.

Current respite policy provides for temporary relief to the unpaid primary caregiver. A review of the evidence presented supports a conclusion the Appellant does not meet current criteria for respite care, if the Appellant's current caregiver is the individual compensated for such services, under the present per diem method of compensation.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Department properly terminated the Appellant's respite care.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc:

Date Mailed: 2/11/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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.