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. 2010-49965 CMH
[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 included [redacted], and [redacted], CMH director, represented the Department. Her witness was [redacted], Synergy, utilization management director, [redacted], Synergy, management director and [redacted], supports coordinator [redacted]

ISSUE

Did the Department properly deny the Appellant's request for an additional 40-hours of Respite?

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 disabled, [redacted]d Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with Mood Disorder NOS, and Downs Syndrome she requires the use of restraints on her arms to stop her from hitting herself. (Department's Exhibit A, p. 3)

3. In [redacted], the parties executed an IPOS which showed 1344 units of respite for the Appellant – among other services. The plan was agreed to and executed by the parties. (See Department's Exhibit A, p. 30)

4. The IPOS is reviewed annually – more often, according to witness [redacted], if circumstances merit reopening the plan. (Department's Exhibit A, p. 31 and See Testimony of [redacted]).

5. Shortly after executing the plan the guardians of the Appellant discovered that they had shorted themselves of 40 hours of respite for a summer school program for the Appellant – they decided to amend the plan but could not get through to decision makers short of this appeal. (See Testimony of [redacted] and Appellant's Exhibit #1)

6. The family was told – incorrectly – that policy forbade the approval of additional Respite hours until previous Respite had been exhausted. (See Testimony of Banks and Domagala).

7. On [redacted] the Department denied the Appellant's request for additional Respite hours. (Department's Exhibit A, p. 34)[1]

8. The instant appeal was received by the State Office of Administrative Hearings and Rules on [redacted]. (Appellant's Exhibit #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,

[1] Not submitted with the Hearing summary.

> 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 she 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. Detroit-Wayne County Community Mental Health Authority contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department. Synergy is a subcontractor of CMH services.

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, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. With regard to respite the manual states:

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[RESPITE]

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)
>
> MPM Mental Health [ ] §17.3. J, Respite Care Services, pp. 110, 111, July 1, 2010

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At hearing the Department witnesses established that the Appellant's request for respite was denied because the Appellant's family was carrying a balance of Respite hours and that policy required them to exhaust that balance first. The Department witness later amended his testimony and acknowledged that there was no such policy – but stated that it [redacted]'s practice to require its clients to exhaust Respite hours before awarding a new balance - usually at the annual IPOS.

The only problem with this approach – according to the Appellant's representative - was getting the Department to listen to her request in April when they had a problem. She said the [redacted] was non-responsive to her inquiries until she filed a request for hearing appealing the denial of Respite in [redacted].

The Department witness explained that the IPOS participants are cautioned to plan carefully and to anticipate normal events – like summer vacations in their planning before approving final plans. However, [redacted] added that in the event of an emergency an IPOS could be opened up at "any time."[2]

On review, it appears that the Appellant had adequate Respite hours to achieve her program goals – however it also appears that the Department was not responsive to her inquiry and factually inaccurate about policy. Like anyone else the Department is required to return phone calls and read their mail irrespective of employee turnover – they ignore these duties at their peril. In this case the issue most likely resolved prior to hearing.

On review the Appellant has failed to preponderate her burden of proof that the Department erred in its denial of her request for additional hours of respite beyond the [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied additional respite to the Appellant.

[2] Here the practice appears to have failed, otherwise the Appellant's denial would have come much sooner.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 11/16/2010

***** 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.