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. 2010-52519 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], ARC, appeared on behalf of the Appellant. Her witness was [redacted] RN, represented the Department. Her witness was [redacted], the Guidance Center.

ISSUE

Did the Department properly reduce in house respite hours from 20 hours a week to 10 hours?

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] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with developmental delay and possible Autism. The Appellant's mother testified that he has a lot of behavior issues. (*See* Testimony of [redacted] and Department's Exhibit A – throughout)

3. On [redacted], the parties executed a Person Centered Plan of Service which documented that the Appellant would receive 20 hours a week of in-home respite services; Personal Assistant (PA) will provide [redacted] with caregiver relief by keeping [redacted] active with different activities or with going

on outings with [redacted]. Respite hours will be assessed every three months. Case manager will update respite authorization every three months. PA will document activities or any behaviors on progress notes during every shift. (Department's Exhibit A, p. 17)

4. The plan is reviewed quarterly as indicated but the Department witness said that that the Appellant's representative wanted to return to work or school – thus the reduction in respite. This too was disputed by the Appellant's representative. (*See* Testimony of [redacted])

5. On [redacted], the Department, by advance action notice notified the Appellant of the reduction of respite effective [redacted], from 20 hours to 10 hours of respite due to clinical appropriateness of level of care. (Department's Exhibit A, p. 8)

6. The Appellant's mother is not employed. There was no evidence presented at hearing that the Appellant's mother was employed or that she expressed intent to be employed on or before [redacted]. (*See also* Department's Exhibit A, p. 17)

7. 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, 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]**
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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)

MPM Mental Health [ ] §17.3. J, Respite, pp. 110, 111, October 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 mother had indicted an intention to return to work. Department witness [redacted] testified that the clinical team had determined that longer term care was no longer necessary at prior levels because the level of care was not indicative of need, but rather child care.

The Appellant's mother testified that the Appellant has not improved and that with her other disabled child the need for stability in their home is great as is the relief that respite provides. She testified that she is not employed.

[redacted] then testified about the Department's responsibility to not supplant DHS services in the home, and while true the CMH is reminded that its contract with the Michigan Department of Community Health and the Medicaid Provider Manual also requires them to assist their beneficiaries in accessing Medicaid services where possible.[1]

The person center plan was executed for up to 20 hours of respite on [redacted] – and for what ever reason the issue of the Appellant's mother voicing an intent to return to work [on a date that was never identified] resulted in a LOC determination that the Appellant now only required simple child care and a resulting reduction in respite by half. [*But see* Finding of Fact #3, above]

There was no reference in the PCP that she was going to do anything. The testimony was certainly inconclusive. From the back and forth at hearing it was clear no one could identify a date when the Appellant's mother uttered an intent to return to work – particularly prior to the advance adequate action notice.

The Department failed to document that either the Appellant or his unpaid caregiver had changed – or that their circumstances had somehow changed on or about [redacted], [redacted]. The reduction in respite is not supported with these facts. This is why methods and amounts should be discussed and documented during the PCP process. MPM §17.3.J

On review, the Appellant preponderated his burden of proof that the Department erred reducing his respite hours from 20 hours a week to 10 hours.

DECISION AND ORDER

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

[1] *See* MPM, [Mental Health] §3, Covered Services, October 1, 2010 at page 15.

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

cc: [redacted]

Mailed: 12/3/2010

***** 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.