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. 2011-1676 CMH
Case No. 38644556

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. She had no witnesses. [redacted], represented the Department. Her witness was [redacted].

ISSUE

Did the Department properly reduce Respite care services to the Appellant from 30 hours per week to 10 hours per week for the time period [one month] of [redacted]?

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 [redacted], non-waiver, Medicaid beneficiary.

2. The Appellant is identified as a person with Down's Syndrome and atrial septal defect (ASD). Her family has received Respite Care Services. Department's Exhibit A, p. 1.

3. The Appellant is assisted in meeting her daily care needs by her family. Department's Exhibit #1 and see Testimony of [redacted].

4. The Appellant's [redacted] has recently abandoned the family. See Testimony of Appellant's [redacted].

5. The Appellant's [redacted] is a person afflicted with paraplegia and limited to a wheelchair. Department's Exhibit A, p. 1.

6. The Appellant appeals a reduction of respite services from [redacted], decision from the CMH to reduce Respite from 30 hours per week to 10 hours per week for the time period of [redacted], for lack of medical necessity. Department's Exhibit A, pp 1, 7 and 8 and *See* Testimony of [redacted].

7. The Department invoked the reduction owing to gradual improvement in the Appellant over time and because of the parental supervision and assistance typically rendered for children of the Appellant's age. Department's Exhibit A, p. 3, paragraph 4.

8. At hearing the Department witness testified that they were not aware that one of the Appellant's [redacted] had recently abandoned his family. See Testimony.

9. [redacted] is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

10. The instant appeal was received by the State Office of Administrative Hearing 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. [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, (MPM) Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[1] it states, in relevant part:

> **[CRITERIA FOR AUTHORIZING]**
>
> 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

[1] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12 – 14, October 1, 2010

- 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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter. (Emphasis supplied) MPM, Mental Health [ ] §17.2 Criteria for Authoring B3 Supports and Services, p. 98, October 1, 2010.

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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, October 1, 2010

At hearing the Department witness established that owing to "improvement" in the Appellant that her delays were not as severe as they were at birth. She added that all [redacted] children [special needs or not] require constant care.

The Appellant's [redacted] said she needs significant assistance with her children, but particularly her special needs child. She added that the [redacted] was no longer present – a fact she had not shared with the CMH.

The person centered plan was executed and approved for up to 30-hours of respite on [redacted], with an expiration date of [redacted]. Within this document were serial references to [redacted] and notation of the [redacted] employment and participation. See Department's Exhibit F, pp. 1 – 6.

On review there was no dispute that the Appellant had improved from her condition at infancy.[2] However, it was equally clear that the Department was unaware that the [redacted] had abandoned the family – as the Appellant's [redacted] clearly testified. On questioning from the ALJ she explained that she had not informed anyone of that development for unknown reasons.

Accordingly, the Department did not have all of the necessary information to make an accurate Respite decision on [redacted]. Furthermore, their action was questionable having referred to their proposed reductions as both Advance Action Notice and Adequate Action Notice – each with different interim payment duties for the Department. See Department's Exhibit A, pp. 3, 5.

It is important to remember that the goals delineated in the PCP are those of the individual.[3] Accordingly the configuration of supports and services must be accurate to enable the Appellant to attain outcomes typical in her community. Without an accurate accounting of the [redacted] whereabouts, [as documented in the Department's Exhibits at E, F and G] the criteria relied upon by the Department under §17.2 of the MPM is meaningless because it presumes dual parental support when it did not exist.

Today, the Appellant proved that the Department erred in its assessment on the proposed reduction of Respite care services.

This Administrative Law Judge must follow the CFR and the state Medicaid policy. Respite hours must be determined with accurate information.

The Department failed to establish an accurate record upon which a decision based on medical necessity could be reached.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH did not properly reduce the Appellant's Respite care services.

IT IS THEREFORE ORDERED that:

The decision is REVERSED.

_____

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[2] The ALJ concurs. *See* Department's Ex. F at page 46.
[3] See §17.1, Definitions of Goals…MPM, *Supra*

[redacted]
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cc: [redacted]

Date Mailed: 1/11/2011

***** 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.