STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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. 2012-12337 CMH
Case No. 38207229

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq*., upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's mother, appeared and testified on behalf of Appellant. [redacted], Due Process Hearing Coordinator, appeared on behalf of the [redacted] County Community Mental Health Services Program (CMHSP). [redacted] and [redacted] also appeared as witnesses for the CMHSP.

ISSUE

Did the CMHSP properly deny Appellant's request for additional respite care 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. Appellant is a [redacted] year-old male who has been diagnosed with autism, Pervasive Development Disorder NOS, and a history of heart problems. (Exhibit 2, pages 1-2, 5).

2. The CMHSP is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMHSP service area.

3. Appellant has been receiving services through the CMHSP, including 4 hours of respite care per week. (Exhibit 2, page 2; Testimony of [redacted]).

4. Appellant's mother subsequently requested an additional 6 hours of respite care per week. (Testimony of [redacted]; Testimony of [redacted]

[redacted]).

5. On [redacted], the CMH sent notice to Appellant notifying him that the request for additional respite hours was denied as "Not medically necessary". (Exhibit 1, pages 1-2).

6. The Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing on [redacted]. (Exhibit 4, page 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 C.F.R. § 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 C.F.R. § 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…
>
> (42 U.S.C. § 1396n(b))

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.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Chapter, articulates the relevant policy and, with respect to respite care services, it states:

> **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 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**.
>
> *(*MPM, Mental Health and Substance Abuse Chapter, October 1, 2011, page 118 (emphasis added)*)*

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230.

Here, Appellant's mother testified that she seeks an increase in respite care hours because the one-on-one time Appellant gets with his respite worker has been greatly beneficial to him and helps with his development.

However, the benefits Appellant is receiving from the respite care are not the expressed purpose of those services. As described in the above policies, respite care is only intended to provide temporary relief to Appellant's caregivers and it does not supplant or substitute for services by paid support/training staff.

In this case, Appellant's mother is not seeking greater respite care for those reasons identified in policy and, instead, requests an increase so that Appellant can benefit from more one-on-one time with his respite worker. Given that Appellant's request is made on an improper basis and not on medical necessity, the decision to deny the additional respite is sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMHSP properly denied Appellant's request for additional hours of respite care.

IT IS THEREFORE ORDERED that:

The CMHSP's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: ___2/6/2012____

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.