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] **Docket No.** 2012-364599 CMH
[redacted]

Appellant
_____/

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], Appellant's mother and co-guardian, appeared on behalf of the Appellant. [redacted], Appellant's sister and co-guardian also appeared as a witness for the Appellant.

[redacted], Due Process Hearings Coordinator, appeared on behalf of [redacted] County Community Mental Health. [redacted], LBSW, Supports Coordinator Supervisor for [redacted], appeared as a witness for the CMH.

ISSUE

Did [redacted] County Community Mental Health (CMH) properly deny respite hours for the Appellant?

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 Medicaid beneficiary receiving HAB Waiver Supports through [redacted] County Community Mental Health (CMH). Appellant's authorized Medicaid services include Supports Coordination and [redacted] hours per week of Community Living Supports (CLS). Appellant also receives [redacted] hours per week of Adult Home Help (AHH) through DHS, and Appellant's [redacted] is paid to provide the AHH for the Appellant. (Exhibit A and testimony).

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area. CMH contracts with [redacted] (MORC) to provide services to its CMH enrollees. MORC is providing the

Supports Coordination for the Appellant's case. (Exhibit A and testimony).

3. The Appellant is a [redacted] year old Medicaid beneficiary [redacted]. The Appellant is diagnosed with profound mental retardation, cerebral palsy, legal blindness, petit mal seizures, neurogenic bladder, and she has a severe latex allergy. (Exhibit A and testimony).

4. The Appellant lives in a single family home with her mother [redacted]. (Exhibit A).

5. On [redacted], Appellant's annual Plan of Service meeting was held in her home. The meeting included Appellant's mother, sister, a family friend, and MORC staff members, including Michele Niebauer the Supports Coordinator Supervisor for MORC. (Exhibit A and testimony).

6. The result of Appellant's Individual Plan of Service (IPOS) meeting was an authorization of Supports Coordination and [redacted] hours per week of CLS services. (Exhibit A).

7. At the [redacted] planning meeting, the Appellant's mother requested [redacted] hours of respite care per week. The CMH did a utilization review of the services previously authorized for the Appellant to determine how many of the hours of services authorized had been used during [redacted]. It was determined that none of the respite hours had been used during [redacted]. The CMH determined that respite services were not medically necessary, and due to Appellant's extensive care needs, an authorization o[redacted] hours of CLS was more appropriate to meet the needs of the Appellant. (Exhibits A&B, and testimony).

8. On [redacted], Appellant was provided with the Appellant's IPOS that was to go into effect on [redacted]. The new IPOS authorized [redacted] hours of CLS, but no hours of respite care were authorized for [redacted]. The IPOS provided Appellant with her rights to a fair hearing, if she did not agree with the decisions made by CMH in he IPOS. (Exhibit A).

9. The Appellant's request for hearing was received by MAHS on [redacted]. In the request for hearing, Appellant's mother stated she was asking for a reinstatement of the respite hours – [redacted] hours per week. (Exhibit C).

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.
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> *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. CMH 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 CMH's witness Michele Niebauer, a licensed social worker, testified she is the Supports Coordinator Supervisor for MORC. [redacted] stated she attended Appellant's annual plan of service meeting held on [redacted] identified Appellant's IPOS that became effective in [redacted] (Exhibit A). [redacted] stated there was a review of the services utilized for the Appellant in [redacted] It was found that the respite hours authorized had not been used and the CLS hours were used intermittently. On average the Appellant used [redacted] hours or less per week of the CLS hours previously authorized.

[redacted] stated based on the needs and the desires of the Appellant and her mother it was decided that the [redacted] hours of services that were identified to be necessary for the Appellant would be better used for CLS. [redacted] stated it was determined that it was important for the Appellant to receive a lot of social interaction, engagement, and help with physical therapy and exercises, which would amount to CLS hours.

[redacted] stated they received a document prepared by Appellant's mother that was the Appellant's "daily total care plan". (Exhibit B). This care plan represented what [redacted] felt were the daily needs of the Appellant [redacted] stated the Appellant was receiving [redacted] hour per week of AHH through DHS. She stated Appellant's mother [redacted] was the one being paid to provide the home help service. [redacted] stated the daily care plan and the AHH hours were both considered in determining what services were needed to meet the needs of the Appellant. [redacted] stated in her professional opinion the [redacted] hours of CLS per week were sufficient in length, scope, and duration to meet the needs of the Appellant.

[redacted] stated respite hours are meant to give an unpaid caregiver a break from their duties in caring for the Medicaid recipient. [redacted] stated due to the way Appellant's care hours are structured there are no "unpaid" hours left during the Appellant's waking hours. [redacted] stated that Appellant could be approved for overnight respite hours if the family wanted to use them. [redacted] reiterated that the services being provided for the Appellant were sufficient to meet her current needs.

The *Medicaid Provider Manual, Mental Health/Substance Abuse* section articulates Medicaid policy for Michigan. It states the following with regard to Habilitation/Supports Waiver for Persons with Developmental Disabilities:

> **SECTION 15 – HABILITATION/SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation/Supports Waiver (HSW) and receive the supports and

services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

15.1 WAIVER SUPPORTS AND SERVICES

Community Living Supports (CLS)

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:

  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.

- Assistance, support and/or training the beneficiary with:

  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from DHS. CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensorymotor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child.

* * *

Respite Care

Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid 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.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

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. The beneficiary's record must clearly differentiate respite hours from community living support services. 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.
>
> 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. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) or MDCH approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.
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> *Medicaid Provider Manual, Mental Health/Substance Abuse*, January 1, 2012, pp. 82-84, 97-98.

[redacted] testified she was the Appellant's mother and guardian. [redacted] acknowledged they had been approved for the CLS hours, but they can't find workers qualified to fill all the CLS hours that have been authorized. [redacted] testified that workers were fired by her because they were taking short cuts and slacking off on the Appellant's care. She stated it is hard to find workers who are trained properly to catheterize. [redacted] stated another worker was fired and the agency discharged themselves from the case when the worker was caught stealing from [redacted]

[redacted] did acknowledge that the appeal she filed dealt with the denial of respite care hours. She said she was not told the care was to be provided to an unpaid caregiver only that it was to give her relief for the constant care that she was providing for the Appellant. [redacted] stated she was [redacted] years old, has fibromyalgia, and she needs to get some rest and a break from caring for the Appellant. She stated she can't keep going 24/7. [redacted] stated she believes there should be sometimes when the Agency cannot fill the hours that she could use respite to get away to do shopping and run errands. [redacted] stated she is essentially home bound due to her circumstances. [redacted] did not believe she could use overnight respite hours. She did not think the respite homes were equipped to provide for Appellant's specific needs such as catheterization. [redacted] also did not want to consider self determination as she was not prepared to screen the workers she would have to hire to come into her home.

[redacted] testified she was the Appellant's sister and co-guardian. She stated she is a registered nurse. Caroline Leon acknowledged that the Appellant was getting [redacted] paid hours per week with the CLS and AHH hours combined. Caroline Leon stated Appellant's mother has to give care in the night and does not get enough rest. Caroline Leon stated she also has to help with caring for her sister due to the lack of available qualified CLS workers.

This administrative law judge must follow the CFR and the state Medicaid policy, and is without authority to grant respite hours not in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it denied authorization for the respite hours for the Appellant's mother. Medicaid policy makes it clear that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not at a time when the beneficiary is

receiving home help or community living supports.

Furthermore, the administrative law judge is limited to making a decision based on the information the CMH had at the time it decided to deny the Appellant's request to reinstate the previously authorized hours of respite care. CMH established that no respite hours had been used by the Appellant the previous year. Appellant's care needs were so extensive that the available hours would be best utilized for providing CLS staff to meet her need for extensive assistance with her activities of daily living. In addition, the Appellant is currently receiving [redacted] AHH hours per week to provide additional assistance with her personal care. Essentially all of the Appellant's waking hours are covered with either CLS hours or AHH hours.

CMH has established that the services authorized for the Appellant are appropriate in length, scope and duration to meet her needs, and that respite care is not appropriate at this time. The Appellant, who bears the burden of proving by a preponderance of evidence that there was medical necessity for respite care, did not meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized Appellant's CMH-provided services, including respite services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-3-12

***** 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.