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. 2012-56804 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], from the [redacted] appeared and testified on [redacted], and [redacted], also testified on [redacted] behalf. [redacted] ut did not participate. [redacted] also testified as witnesses for the [redacted]

ISSUE

Did the [redacted] properly deny [redacted] request for an additional 24 hours per week of services during the summer and, instead, only authorize an additional 84 respite 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] share joint physical and legal custody of him, with Appellant living with his [redacted] during the week and [redacted] during weekends. (Exhibit 1, pages 8-9, 33, 46, 80).

2. Appellant attends [redacted] program at his elementary school. Appellant also receives occupational therapy and speech and language services at school. (Exhibit 1, page 35).

3. The [redacted] is under contract with the [redacted]

[redacted] to provide Medicaid covered services to people who reside in the CMH service area. In turn, the [redacted] contracts with [redacted] to provide services to its clients. ([redacted]

4. Appellant's [redacted] applied for services with the [redacted] on behalf of Appellant and, on [redacted] a personal plan meeting took place. Following that meeting it was decided that the personal agent would submit a referral for a psychiatric evaluation of Appellant while a social worker would try to get occupational therapy and speech and language therapy authorized. Supports Coordination, patient education, and a fiscal intermediary were authorized at that time. It was also noted that Appellant had requested Community Living Supports, and that respite care would be authorized until Community Living Supports were granted. (Exhibit 1, pages 7-31, 37-42).

5. On [redacted] Appellant's plan was amended. [redacted] new plan contained [redacted] per week and [redacted] of transportation each week. (Exhibit 1, pages 44, 47, 54).

6. [redacted] and his [redacted] were also given notice of their right to appeal the amendment to the plan. (Exhibit 1, pages 55-61). No appeal was filed at that time. ([redacted]

7. In [redacted] Appellant's [redacted] requested additional service hours on behalf of his [redacted]. According to Appellant's [redacted] the additional hours were necessary because [redacted] would not be attending school full-time during the summer and would be home more. (Testimony of [redacted]

8. Specifically, Appellant's [redacted] requested an additional 24 hours of services per week during the summer. It did not matter to [redacted] or respite hours. (Testimony of [redacted]).

9. The summer school schedule at Appellant's school was 9:30 a.m. to 12:30 p.m., 2 to 4 days a week, for 7 weeks. (Exhibit 1, page 80; Exhibit 5, page 1).

10. On [redacted] sent Appellant written notice that it was denying the request to increase his [redacted] notice also stated "[t]he reason for this action is because Heith currently receives 16 hours weekly of [redacted] which meets the medical necessity for staffing. Parental responsibility indicates it is [redacted] responsibility to meet the needs of [redacted] during the summer while not in school." (Exhibit 1, pages 69).

11. Subsequently, during a meeting at [redacted] school, A[redacted] again requested an increase in [redacted] services. The request was once again based on the fact that [redacted] would be home more during the summer. ([redacted]

12. On [redacted] Community Living Services sent [redacted] written notice that it was denying any request to increase his Community Living Supports, but that it would authorize an additional 84 hours of respite to be used during the summer. (Exhibit 1, pages 85-89).

13. The reasoning given in the notice was that '[redacted] request is for the summer 2012 while [redacted] is not in school full-time, as [redacted] will be working. [redacted] will be attending the summer school program at school this year from 9:00am.-12:30pm [sic] for 7 weeks (ranging from 2-4 days weekly). [redacted] of [redacted] and are a natural support for [redacted]. It is reasonable to expect that [redacted] with a [redacted] without a disability and meet the needs of the [redacted] erm, intermittent basis; it is not intended to be part of the daily services that will enable an unpaid caregiver to work elsewhere full-time. Nothing [sic] that [redacted] has exhausted [redacted] current respite allocation, Community Living Services will authorize up to an additional 84 hours of respite to begin [redacted] It is further noted that [redacted] currently receives 16 hours of [redacted] weekly, the [redacted] and [redacted]. It is suggested that [redacted] incorporate those [redacted] hours and [redacted] SSI payments into the appropriate use of [redacted] support strategies. [redacted] application process has been started by [redacted] for [redacted] (Exhibit 1, page 85).

14. On [redacted] the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed on behalf of [redacted] In that request [redacted] representatives assert that, while [redacted] receives a total of 28 hours of services per week, those services are insufficient given the severity of his disability. [redacted] representatives also note that [redacted] cannot attend a typical day care center or be taken care of by just any babysitter. The request further argues that [redacted] works on a schedule and cannot pay for additional care at the level [redacted] requires. (Exhibit 2).

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 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 USC 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.

Here, Appellant was receiving 16 hours per week of Community Living Supports when Appellant's father requested an additional 24 hours per week of services during the summer. As discussed above, it made no difference to Appellant's father if the additional hours were granted as Community Living Supports or respite hours. After initially denying the request, the CMH and Community Living Services eventually authorized an additional 84 hours of respite care for the summer. For the reasons discussed below, this Administrative Law Judge finds that the CMH's decision should be affirmed.

Both Community Living Supports and respite care are Medicaid covered services, but 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.

With respect to medical necessity, the Medicaid Provider Manual states:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
>
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- Documented in the individual plan of service.

(MPM, Mental Health and Substance Abuse Section, April 1, 2012, pages 12-13)

Moreover, in addition to requiring medical necessity, the MPM also states that B3 supports and services, such as respite care services and Community Living Supports, are not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> 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.
>
> (MPM, Mental Health and Substance Abuse Section, April 1, 2012, page 106 (emphasis added))[1]

Regarding Community Living Supports, the MPM provides:

[1] The attorney for Community Living Services moved for a dismissal of this action due to a lack of jurisdiction on the basis that B3 services, such as respite care and Community Living Supports, are not intended to meet all the individual's needs. However, even though B3 services are not intended to meet all the individual's needs and preferences, they are still a Medicaid covered services and the denial of such services gives rise to the right to a Medicaid Fair Hearing. *See* the Code of Federal Regulations: 42 CFR 431.200 *et seq.* and 42 CFR 438.400 *et seq.*

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

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

  > meal preparation

  > laundry

  > routine, seasonal, and heavy household care and maintenance

  > activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

  > shopping for food and other necessities of daily living

  CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (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 case manager or supports coordinator must assist him/her in

requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  > money management

  > non-medical care (not requiring nurse or physician intervention)

  > socialization and relationship building

  > transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

  > participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

  > attendance at medical appointments

  > acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential

> Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.
>
> CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living 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 the DHS's allowable parameters. 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. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.
>
> (MPM, Mental Health and Substance Abuse Section, April 1, 2012, pages 108-109)

In this case, the CMH properly found that any additional Community Living Supports beyond the 16 hours per week [redacted] was already receiving were not medically necessary. As found by the CMH, Appellant was receiving 16 hours per week of Community Living Support while in school and those hours were considered sufficient at the time by both the CMH and by [redacted], given the lack of any appeal after those hours were awarded. The only change on Appellant's circumstances since the authorization of the 16 hours is that he is in school less.

Moreover, it is clear that [redacted] is essentially seeking child care and just wants someone to watch [redacted] given the change in circumstances. This is not a case of increased medical needs. [redacted] representative did argue the absence of full-time school has lead to a lack of routine for [redacted] and a need for more [redacted] but there is no evidence in the record of such a need. It is also clear from [redacted] testimony that the request for more hours is simply based on [redacted] being around more and not on any increased need for training, guidance or assistance.

Given the above policy and Findings of Fact, the Respondent properly denied [redacted] request for an increase in [redacted] father did not seek additional [redacted] for appropriate reasons and, as argued by Respondent, simply sought child care for a period of time while [redacted] was home more often. [redacted] are not to be used for child care and must be a medically necessary service "used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion

and participation, independence or productivity." ([redacted]ce [redacted] page 108). A [redacted] worker is not a babysitter and, instead, is suppose to assist, support or train a beneficiary with respect to the development of identified skills and activities. [redacted] is not seeking such development, support or training. Instead, he merely seeks someone to watch [redacted]t. Accordingly, his request for additional [redacted] was properly denied.[2]

With respect to respite care services, the MPM states:

> **17.3.J. RESPITE CARE SERVICES**
>
> Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided 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. 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.
>
> - "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 a time period in between.

[2] Community Living Services' representative also argues that Appellant's father and caregivers have been using Community Living Supports incorrectly and that they already use it as child care. Appellant's representative and witnesses dispute that characterization. In any event, Respondent did not base the denial of additional Community Living Supports on that reason and there were sufficient other reasons it did have for denying the request.

- "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 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.

(MPM, Mental Health and Substance Abuse Section, April 1, 2012, pages 118-120)

As stated above, "[r]espite care services are intended to assist in maintaining a goal of living in a natural community home and are provided 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." [redacted] pages 118-119). Here, the change in [redacted] school from full-time to part-time could logically lead to an increased need for respite as [redacted] s around more and needs to be cared for more often, which could increase his caregivers' daily stress and care demands

However, [redacted] situation is not unusual and most children are out of school for the summer. As noted by Respondent, a review of the MPM supports the CMH's position that B3 supports and services are not intended to meet all of an individual's needs and that it is reasonable to expect that [redacted] would provide care for the period of time proposed by the CMH without use of Medicaid funding: "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." MPM, Mental Health and Substance Abuse Section, [redacted] page 106).

Additionally, other factors also support the [redacted] decision to limit the additional respite hour authorization. For example, [redacted] shares joint custody of [redacted] with [redacted] spends his weekends with her. During the hearing, [redacted] testified that [redacted] cannot care for [redacted] but there is no such claim [redacted] plan and it is undisputed that she has joint custody of [redacted] Similarly, the presence of some summer school and [redacted]

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying his full request for additional respite hours and, instead, only authorizing an additional 84 respite hours. Here, given the policy on B3 services and the presence of other factors suggesting a lessened need for respite, Appellant has failed to meet that burden of proof. Accordingly, the [redacted] decision on respite hours must also be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied [redacted] request for an additional 24 hours per week of services during the summer and, instead, only authorized an additional 84 respite hours

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Steven Kibit

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

cc: [redacted]

Date Mailed: _____

***** 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.