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) 373-4147

IN THE MATTER OF

[redacted],
Appellant

Docket No. 2013-38139 CMH
Case No. [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], Appellant's mother, appeared and testified on Appellant's behalf. [redacted], a family friend, appeared as a witness for Appellant.

[redacted], Chief Operations Officer, [redacted] CMH (CMH or Department), represented the Department. [redacted], Supports Coordinator; [redacted], Utilization Manager; [redacted], DDA Clinical Supervisor; and [redacted], Supports Coordinator, appeared as witnesses for the Department.

ISSUE

Did the CMH properly reduce Appellant's 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 Medicaid beneficiary receiving services through [redacted] CMH. (Exhibit A, Testimony)

2. CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony)

3. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted]. Appellant is diagnosed with cerebral palsy, legal blindness and a seizure disorder. (Exhibit A, p 13; Testimony).

4. Appellant lives in his family home with his mother and brother in [redacted], Michigan. Appellant's father is deceased. The family currently provides total support for Appellant and needs respite in order to keep Appellant in the least restrictive setting and to prevent burn-out of the caregivers. (Exhibit A, p 18; Testimony).

5. Following the development of Appellant's annual Individual Plan of Service (IPOS), Appellant's respite hours were reduced from 12,288 units per year (approximately 60 hours per week) to 3,424 units per year (approximately 16-17 hours per week). (Exhibit A, pp 26-30; Exhibit 1; Testimony).

6. On [redacted], Pathways sent an Adequate Action Notice to the Appellant notifying him of the reduction in respite hours. The notice included rights to a Medicaid fair hearing. (Exhibit A, pp 34-35).

7. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (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 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…

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.

The *Medicaid Provider Manual (MPM), Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Appellant is receiving services under Section 17 of the MPM – Additional Mental Health Services (B3's). With regard to B3's, the MPM provides in part:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
>
> * * * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

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
- 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.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Section*
> *April 1, 2013, pp 110-111*

The MPM states with regard to respite care services:

> **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.
>
> - "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).
>
> - Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in

a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

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.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Section*
> *April 1, 2013, pp 124-125*

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 is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve his goals.

The CMH Supports Coordinator testified that Appellant's original request for approximately 60 hours of respite per week was made as part of the annual IPOS process. The CMH Supports Coordinator testified that Appellant had been receiving that amount of respite in the past and his mother wished to continue with that amount of respite in the new IPOS. The CMH Supports Coordinator testified that the CMH has a new approval process for authorization of services, including respite, so he submitted Appellant's respite request for authorization. The CMH Supports Coordinator testified that when he met with Appellant's mother for the IPOS, no decision had yet been made regarding respite. The CMH Supports Coordinator testified that he was later contacted by the CMH Utilization Manager, who informed him that Appellant's request for respite was much higher than the average for someone with Appellant's diagnosis and also seemed to not fit under the definition of respite found in the MPM. The CMH Utilization Manager asked the CMH Supports Coordinator to meet with Appellant's family again to discuss alternatives to the requested respite. Upon speaking with Appellant's mother, the CMH Supports Coordinator learned that the family was not interested in pursuing alternatives at that time and wanted respite authorized at the same level it had been in the past.

The CMH Supports Coordinator believed that he could authorize respite services at the same rate as the previous year and that those services could remain in place while the Appellant appealed. However, the CMH Supports Coordinator later learned that because the reduction was done as part of the annual IPOS, the respite hours could only be authorized at the new, lower amount, (approximately 16-17 hours per week), and could only continue at that level while the appeal was pending. In other words, Appellant's respite at 60 hours per week simply expired at the end of the previous IPOS, so the CMH Supports Coordinator could not continue those hours into the new IPOS while Appellant's appeal was pending. The CMH Supports Coordinator then sent to Appellant an Adequate Action Notice notifying him of the reduction in respite hours.

The CMH Utilization Manager testified that when services are requested for a client that go beyond the benefit plan, those requests come to her for review. The CMH Utilization Manager explained that the benefit plan is not a preset limit on services but rather a general guideline for services developed from an average of services used by clients with similar diagnoses and circumstances. The CMH Utilization Manager testified that the respite services Appellant was receiving were B3 services and, as such, were subject also to the CMH's ability to pay for those services in light of the needs of all clients at the CMH. The CMH Utilization Manager testified that when she received the request for Appellant's respite in the instant matter, she immediately noticed that the hours were way above the average amount of respite used by other clients with similar diagnoses and circumstances as Appellant. The CMH Utilization Manager also reviewed the Medicaid Provider Manual (MPM) and determined that the respite requested did not meet the definition in the Manual because it was not being used on a short-term or intermittent basis. The CMH Utilization Manager testified that she contacted Appellant's Supports Coordinator and requested that he go back to Appellant's family, explain the situation to them, and see if they would be willing to look at other services in place of the respite. As indicated above, the CMH Supports Coordinator did discuss this with Appellant's mother, but she chose not to pursue alternatives until the instant appeal was resolved.

The CMH Utilization Manager testified that she then looked at Appellant's care requirements, his family and community supports, and determined that he would be eligible for approximately 16-17 hours per week of respite. The CMH Utilization Manager explained that respite is designed to provide a break for the family; it is not a care service for the consumer. The CMH Utilization Manager testified that it was clear that Appellant's family had been using respite time to care for the Appellant, contrary to the definition of respite in the MPM.

The CMH DDA Clinical Supervisor testified that she also met with Appellant's mother and Supports Coordinator on two occasions to try to assess Appellant's needs and determine appropriate services for Appellant in light of the change in respite services. The CMH DDA Clinical Supervisor testified that Appellant's mother is also paid for 9.5 hours per day of service through the Department of Human Services (DHS) Home Help Program (HHS). The CMH DDA Clinical Supervisor testified that Appellant's mother again refused to consider alternatives, such as Community Living Supports (CLS), until the instant appeal was resolved. The CMH DDA Clinical Supervisor testified that Appellant's mother used 16-17 hours of respite for two weeks following their meeting, but then returned to using 60 hours of respite per week.

Appellant's mother testified that Appellant has been receiving 60 hours of respite per week for 8 years and she could not understand why there was a change. Appellant's mother indicated that Appellant's needs have only worsened during that time and the definition of respite in the MPM has remained exactly the same. Appellant's mother testified that she had always been told by Appellant's previous Supports Coordinators that their use of respite was appropriate under the definition of respite in the MPM

because the hours were used intermittently. Appellant's mother went on to explain the intense amount of care that her son needs. Appellant's mother testified that Appellant deserves the care and that her other son, who is the caregiver being paid through Appellant's respite hours, makes less than $[redacted] an hour, so any other service would be much more expensive. Appellant's mother testified that she will not allow her son to go into a home.

Appellant bears the burden of proving by a preponderance of evidence that the reduction in respite hours was improper. Based on the evidence presented, Appellant has failed to meet that burden. While it is unfortunate that Appellant was allowed to receive so much respite for so many years, that does not change the fact that the respite was clearly being used to care for Appellant, not to provide Appellant's family a break from care.

As indicated clearly in the definition of respite in the MPM, respite services are to be "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. . ." The MPM goes on to define short-term to mean that "the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations)," and "intermittent" to mean that "the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between." Here, Appellant was receiving respite services 12 hours a day, 5 days a week for 8 years. Clearly, there is nothing in that usage that would equal a few hours, a few days, weekends or for vacation. 60 hours a week for 8 years is also clearly regular and continuous.

In cases such as Appellant's, the proper form of service would be through Community Living Supports (CLS), with respite used as it was intended, to provide short breaks to Appellant's caregivers when they are providing unpaid care. Appellant's mother is encouraged to work with the CMH to come up with a plan using CLS, respite, and any other appropriate services to meet Appellant's needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly reduced Appellant's respite hours.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: 5/23/2013

Date Mailed: 5/24/2013

***** 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.