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:

Docket No. 2013-60818 CMH

,

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 a Request for Hearing filed on behalf of Appellant/Petitioner.

After due notice, a hearing was held on Appellant's father and power of attorney, appeared and testified on Appellant's behalf. one of Appellant's caregivers; , another of Appellant's caregivers; and , Appellant's supports coordinator; testified as witnesses for Appellant. , attorney and Due Process Hearings Coordinator, represented Respondent County Community Mental Health the Assistant Director of Community Supports at , the Self-Determination Coordinator at vices County; and , Clinical Analyst at testified as witnesses for Respondent.

Following the hearing, the record was left open at the request of Appellant's representative until , so that Appellant's representative could submit additional evidence.

ISSUE

Did Respondent properly deny Appellant's request for an additional four (4) days of respite care services per month?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

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

2. In turn, contracts with service providers such as ity to provide Medicaid covered services.

3. Appellant is an year-old male who has been diagnosed with severe autism, cognitive impairment, bipolar disorder, obsessive compulsive disorder, and a seizure disorder. (Testimony of Appellant's representative).

4. As noted in the Individual Plan of Service (IPOS) in place for Appellant at the time of the request at issue in this case, Appellant generally requires direct monitoring at all times during the day and one-on-one assistance in completing most of his activities of daily living. (Respondent's Exhibit F, pages 3-4, 16).

5. Appellant's IPOS also provided, with respect to his need for individual monitoring at night, that:

> Sleeping hours- is never left alone in the home, however, he does not require direct monitoring while asleep. will occasionally becomes [sic] escalated in the evening hours and will sleep minimally during these times. reported that he often has to stay awake through the night with to attempt to calm him and get him back to sleep, if he goes back to sleep. generally wakes up in the middle of the night for at least an hour and requires one on one assistance to get back to sleep.

Respondent's Exhibit F, page 17

6. Appellant lives with his father and his father is his sole natural support. (Testimony of Appellant's representative).

7. Appellant has been receiving services through the and (Testimony of).

8. At the time of the denial at issue in this appeal, Appellant was receiving services pursuant to the IPOS developed for the time period of through (Respondent's Exhibit F, pages 1-22).

9. Among other services identified in that IPOS, Appellant was receiving receives supports coordination, medication reviews, fiscal intermediary services, community living supports (CLS), and respite care services. (Respondent's Exhibit F, page 21).

10. From to , CLS was approved for hours a week. From to , it was approved for hours a month. (Respondent's Exhibit F, page 21).

11. With respect to in-home respite care services, Appellant was approved for hours a week from to From to , in-home respite was approved for and hours per month. (Respondent's Exhibit F, page 21).

12. Appellant was also approved for out-of-the-home respite care services and, while the authorization referenced a number of days for such service, it was generally approved as a dollar amount, , and used for summer camp at the with Appellant paying any camp costs over . (Respondent's Exhibit F, pages 1, 21; Testimony of Appellant's representative).

13. In , Appellant and his representative requested an additional days of in-home respite care services each month. (Testimony of Appellant's representative; Testimony of ; Testimony of).

14. According to Appellant's representative, Appellant's need for assistance at night due to his manic episodes and sleep issues was leaving his caregivers exhausted and unable to provide normal care during the day. (Testimony of Appellant's representative).

15. On sent Appellant written notice that the request for additional respite care services was being denied as the services were not medically necessary. (Respondent's Exhibit A, pages 1-2).

16. On , the Michigan Administrative Hearing System (MAHS) received a Request for Hearing with respect to that denial.

17. On , MAHS sent the parties written notice regarding a telephone hearing scheduled for

18. On or about [redacted] Appellant's representative sent in a request that the telephone hearing be rescheduled as an in-person hearing.

19. On [redacted] MAHS sent the parties written notice regarding a rescheduled in-person hearing on [redacted]

20. While Appellant's appeal was pending, a new IPOS was developed for Appellant. (Respondent's Exhibit C, pages 1-18).

21. Appellant's goals and the types of services he is receiving essentially remained the same in the new IPOS, but his CLS hours were increased to [redacted] hours per month. (Respondent's Exhibit B, page 1; Respondent's Exhibit C, page 11).[1]

22. The in-person hearing was held on [redacted]

23. Following the hearing, the record was left open until [redacted] at the request of Appellant's representative so that Appellant's representative could submit additional evidence.

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*

* * *

[1] The number of days referenced in the approval for out-of-home respite care services was also increased, but it appears that the total dollar amount authorized for such services remained the same. (Respondent's Exhibit B, page 2; Respondent's Exhibit C, page 11),

> 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

Moreover, 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.

The [redacted] contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Among the services that can be provided by the [redacted] are respite care services. With respect to respite care services, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **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.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 124-125

However, while respite care services are Medicaid-covered services, Medicaid beneficiaries are only entitled to medically necessary covered services for which they are eligible and 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.

With respect to medical necessity, the MPM provides:

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;

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

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

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

- Made within federal and state standards for timeliness;

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

- Documented in the individual plan of service.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 12-13

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as respite care services:

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.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended

outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

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.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 110-111

Here, it is undisputed that Appellant needs some respite care services and it is only the amount of hours to be authorized that is at issue. As discussed above, while the and service provider are willing to authorize and hours per month of in-home respite care services and worth of out-of-home respite care services, Appellant's representative is requesting an additional days of in-home respite care services per month.

Appellant bears the burden of proving by a preponderance of the evidence that the /service provider erred in denying his request for additional respite care services. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

According to Appellant's representative, he is seeking the additional respite care services because Appellant's need for assistance at night due to his manic episodes and sleep issues is leaving his caregivers too exhausted to provide normal care during the day.

In response, Short testified that Appellant is receiving a significant, higher-than-average, amount of respite care services already and that, in allocating B3 services such as respite care services, the "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 111).

Moreover, while this particular request for additional respite appears appropriate as it is for unexpected situations caused by Appellant's issues at night, the significant amount of respite care services Appellant is already receiving are not being provided on a short-term, intermittent basis as required by policy. As defined in the applicable policy, "'Short-term' means the respite service is provided during a limited period of time" while "'Intermittent' means the respite service does not occur regularly or continuously." (MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 124). In this case, however, the respite care are regular, scheduled, and long-term services utilized as part of the daily schedule ensuring that Appellant is cared for at all times. Other services that may be more appropriate on a regular, long-term basis would be CLS, which Appellant is already receiving and which was increased in the most recent IPOS, and Adult Home Help, which Appellant is in the process of applying for.

Additionally, while the request for additional respite care services is based on circumstances caused by Appellant's issues at night, those circumstances were already considered and addressed in Appellant's IPOS and the previous authorization of respite care services. As discussed above, with respect to Appellant's needs at night, his IPOS always stated:

> Sleeping hours- [redacted] is never left alone in the home, however, he does not require direct monitoring while asleep. [redacted] will occasionally becomes [sic] escalated in the evening hours and will sleep minimally during these times. [redacted] reported that he often has to stay awake through the night with [redacted] to attempt to calm him and get him back to sleep, if he goes back to sleep. [redacted] generally wakes up in the middle of the night for at least an hour and requires one on one assistance to get back to sleep.

Respondent's Exhibit F, page 17

Similarly, it is undisputed that, in making the request for additional respite, Appellant's supports coordinator reported that nothing had changed with respect to Appellant's needs or circumstances. (Testimony of [redacted]; Testimony of [redacted]; Testimony of [redacted]). This Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time of its decision and, in this case, no new information was provided justifying an increase in respite care services over what was previously authorized.

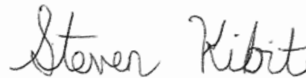
Taking into account those reports and the fact that Appellant's previous IPOS addressed Appellant's issues at night, in addition to the significant respite care services Appellant already received on a regular basis, this Administrative Law Judge finds that Appellant has failed to meet his burden of proof with respect to the denial of additional respite care services. Accordingly, the Respondent's decision is affirmed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Respondent's decision is **AFFIRMED**.



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

Date Signed:

Date Mailed:

SK/db

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***** 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.