

**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.** 2013-67337 CMH  
**Case No.** ██████████

**Appellant**  
\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████ and ██████████, Appellant's guardians, appeared and testified on Appellant's behalf.

██████████, Due Process Hearings Coordinator, appeared on behalf of Genesee Health System (CMH or Department). ██████████, RN, Utilization Management, appeared as a witness for the Department.

**ISSUE**

Did the CMH properly deny Appellant's request for 96 hours per month of respite and authorize 53 hours per month of respite?

**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 ██████ year old Medicaid beneficiary, born ██████████, who has been receiving services through ██████████ (CMH). (Exhibit A, p 1; 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. (Testimony)
3. Appellant is diagnosed with hypotonia, cerebral palsy, dyskinesia, dysphagia, status epilepticus, developmental delay, obstructive sleep apnea, brain atrophy, seizures and respiratory failure. Appellant is fed through a G-tube. (Exhibit A, p 3; Testimony)

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4. Appellant lives with her guardians in a three story home in ██████████ Michigan. (Exhibit A, p 23)
5. Appellant's female guardian is her primary caregiver and she does not work outside of the home. Appellant's female guardian has recently had knee surgery, and has shoulder problems. Appellant's male guardian is on medical disability and fixes up properties in the area to rent out. Appellant's guardians have no family or informal supports who are able to assist with Appellant's care. (Exhibit A, pp 2-3; Testimony)
6. Appellant has not been to school since ██████████ due to being in and out of the hospital and medical issues. (Exhibit A, p 3; Testimony)
7. Appellant requires three or more interventions per night and the time required to complete the interventions is more than one hour. (Exhibit A, p 3; Testimony)
8. On ██████████, Appellant's guardian requested 96 hours of respite per month. Following a respite assessment, CMH determined that Appellant's guardian was approved for 52 hours of respite per month. (Exhibit A, pp 1-5; Testimony)
9. On ██████████, CMH sent an Adequate Action Notice to Appellant's guardians notifying them that the request for 96 hours of respite per month was denied, but that 52 hours of respite per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit A, pp 6-7)
10. The Michigan Administrative Hearing System received Appellant's request for hearing on ██████████. (Exhibit 1)
11. At the hearing on ██████████, the CMH indicated that due to a calculation error, Appellant has actually been approved for 53 hours of respite per month. (Testimony)

**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.

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 *Medicaid Provider Manual, Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan. It states with regard to respite:

### **17.3.J. RESPITE CARE SERVICES**

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid primary caregiver (e.g., family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

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

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 her goals.

The CMH witness who reviewed and scored Appellant's Respite Assessment testified that Appellant was awarded 2 respite hours because Appellant has two or more caregivers, one of whom works or is in school full-time or part-time, 2 respite hours because Appellant's primary caregiver has health issues that interfere with the provision of care to Appellant, and 4 respite hours because Appellant requires 3 or more interventions per night and the time to complete the interventions is more than 1 hour. The CMH witness also testified that she awarded 3 respite hours because Appellant is physically abusive to herself on a daily basis and 1 respite hour because Appellant has weekly temper tantrum. The CMH witness testified that Appellant was awarded 24 respite hours for mobility and self-care, the maximum allowable, because Appellant requires total physical assistance in those areas. The CMH witness also testified that Appellant was awarded an additional 8 respite hours for dietary care, grooming, and an exercise program, although normally a person would not be awarded additional hours in these areas after receiving the maximum number of hours in the areas of mobility and

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self-care. The CMH witness testified that the Respite Assessment resulted in a total of 53 respite hours per month.

The CMH witness testified that a person can reach 96 hours of respite per month using the Respite Assessment tool used here, that respite is meant to be a short-term and intermittent service, and that the CMH is allowed to utilize various tools in order to assess clients' respite needs. The CMH witness indicated that, in her professional opinion, the 53 respite hours approved per month accurately reflects the needs of Appellant.

Appellant's guardians testified that caring for Appellant is like a job in that for every 8 hours worked, they should be entitled to a 1 hour lunch break and 2 – 15 minute breaks, which would equal 3 respite hours per day, exactly what they are asking for. Appellant's guardians indicated that 3 respite hours per day would give them a chance to get out of the house, go to church, and actually do some activities together. As it is now, Appellant's guardians indicated that one or the other always has to stay with Appellant. Appellant's guardians testified that the Medicaid Provider Manual indicates that respite decisions should be based on person centered planning and be individualized. Appellant's guardians indicated that Appellant does not meet the norm and the usual respite assessment does not work for her. Appellant's guardians asked that the normal formula for determining respite should be bypassed in Appellant's case and it should be determined that 3 hours of respite per day is reasonable.

Appellant's guardians testified that in the past they had been approved for 88 hours of respite per month and that respite was then reduced to 33 hours per month. Appellant's guardians indicated that since [REDACTED] Appellant does not move on her own and someone has to be with her at all times. Appellant's guardians testified that they cannot even go downstairs to the kitchen to cook a meal. Appellant's guardians testified that Appellant's alarm is going off 24 hours per day and they need a break just so they are able to think straight.

In response, the CMH witness testified that respite hours can be used at the discretion of Appellant's guardians and can be combined to be used in 3 hour chunks, or however long Appellant's guardians feel appropriate, within the monthly limit. The CMH witness indicated that respite is not intended to be used on a daily basis, but rather is intended to be used here and there. Finally, the CMH witness indicated that Appellant's respite assessment was done on an individualized basis.

Appellant bears the burden of proving by a preponderance of the evidence that the Appellant was entitled to 96 respite hours per month. The testimony of Appellant's guardians did not meet the burden to establish medical necessity for 96 respite hours per month. The respite assessment utilized by the CMH is reasonable and appropriate and it was applied to Appellant's needs on an individualized basis. Appellant's guardians could point to nothing specifically wrong with how the respite assessment was scored, but rather just asked that the respite assessment process be bypassed in this case and that they be approved for 3 respite hours per day. However, the

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undersigned does not have the authority to order the CMH to bypass its regular respite assessment process; only the ability to make sure that the process was properly implemented. Here, there is no evidence that the calculation of Appellant's respite needs was improper.

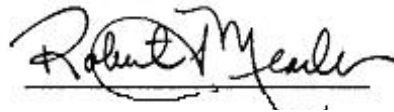
As such, the evidence presented by the Department supports the conclusions it reached with regard to respite based on the information it had at the time the decision was made.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant's request for 96 hours per month of respite and properly authorized 53 hours per month of respite.

**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

cc: [REDACTED]

Date Signed: 12/10/2013

Date Mailed: 12/10/2013

**\*\*\* 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.