STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 14-018153 CMH

[redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted], Appellant's mother/guardian appeared and testified on behalf of the Appellant.

[redacted], Due Process Manager, appeared on behalf of [redacted] Community Mental Health Authority (CMH), representing the Department. [redacted], LBSW, [redacted]) Director of Community Services, appeared as a witness for the Department.

ISSUE

Did CMH properly reduce Appellant's respite care services?

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 was a [redacted]-year-old Medicaid beneficiary ([redacted] at the time of the hearing. (Exhibit A, p. 3 and testimony).

2. [redacted] Community Mental Health (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. Appellant was receiving Medicaid covered services under the HAB waiver, including [redacted] overnight respites per year and another [redacted] hours per week of in-home respite care. (Exhibit A, p. 1 and testimony).

4. Effective [redacted] authorized a new Individual Plan of Service (IPOS) for the Appellant. In the new IPOS Appellant's overnight

respites were reduced to [redacted] overnights per year and the in-home respite hours of [redacted] hours per week were eliminated. Appellant was also authorized to receive Supports Coordination and Community Living Supports (CLS). Appellant attends a vocational/skill building program out of the home at [redacted] hours per day [redacted] days per week. Appellant receives transportation to and from [redacted] provided by [redacted]. He also receives [redacted] hours of Adult Home Help Services per day through DHS. (Exhibit A, pp. 8-24 and testimony).

5. On [redacted], MAHS received the Appellant's Request for Hearing. (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*].
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> 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) Medicaid Managed Specialty Services waiver. Oakland County Community Mental Health Authority (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

The *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, October 1, 2014 specifies what supports and services are available for persons such as the Appellant. This chapter provides in pertinent part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES [CHANGES MADE 7/1/14]**
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> 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. [p. 96].
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> *** * ***
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> **15.1WAIVER SUPPORTS AND SERVICES [CHANGE MADE 7/1/14]**
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> *** * ***
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> **Respite Care**
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> 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/IID, **(revised 7/1/14)** 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. [pp. 97, 111-112, emphasis added].

In this case, it is undisputed that respite services are medically necessary for the Appellant. Effective [redacted] authorized a new Individual Plan of Service (IPOS) for the Appellant. In the new IPOS Appellant's overnight respites were reduced to [redacted] overnights per year and the in-home respite hours were eliminated. Appellant was previously receiving [redacted] overnight respites per year and another [redacted] hours per week of in-home respite care. Appellant was also authorized to receive Supports Coordination and Community Living Supports (CLS). Appellant attends a vocational/skill building program out of the home at [redacted] hours per day [redacted] days per week. Appellant receives transportation to and from New Horizons provided by [redacted]. He also receives [redacted] hours of Adult Home Help Services per day through DHS.

The witness for CMH, [redacted], LBSW, [redacted] Director of Community Services, testified she was responsible for reviewing the Appellant's request for respite services. [redacted] stated she reviewed the Appellant's services and how they were used during the previous year; she reviewed his current status, and his other supports and services to determine the amount, scope and duration of the services to be approved for his new IPOS. [redacted] stated the Appellant has been stable both behaviorally and health wise for the past year. She stated he was attending his vocational program regularly and on average he was out of his home between [redacted] and [redacted] hours per day five days per week. [redacted] stated the Appellant also receives [redacted] hours of Adult Home Help Services per day through DHS for personal care. She stated the Appellant has a baclifin pump for his spasticity as he has a diagnosis of cerebral palsy.

[redacted] stated the purpose of respite is to provide an intermittent break for the unpaid caregiver. She stated the Appellant's family typically uses the respite as out of the home overnight respites at [redacted]. [redacted] acknowledged that the Appellant was authorized [redacted] overnights for the previous year.

[redacted] said the family used [redacted] of the [redacted] overnights for the previous year. [redacted] stated that in looking at the Appellant's total supports it was determined that [redacted] overnight respites were sufficient to provide the Appellant's unpaid caregiver a break as contemplated in the Medicaid policy quoted above. [redacted] stated that in her professional opinion [redacted] overnight respites were reasonably sufficient to meet the family's needs for a break from caregiving.

Appellant's mother testified they did use all [redacted] respite overnights previously authorized for the Appellant and have always used all the overnights that were approved. Appellant's mother admitted that the Appellant was stable at the time they completed the review for Appellant new IPOS. She said the Appellant is non-verbal and functions like an infant so he requires a lot of assistance. Appellant's mother said the Appellant gets frustrated and aggravated if he doesn't get a break from the family. She said they can do without the in home hourly respite services that were ended, but would like to get back to the [redacted] overnight respites that were authorized for the past year.

The Appellant bears the burden of proving by a preponderance of the evidence that the previously authorized [redacted] overnight respites should remain in effect. The Appellant's witness was given an opportunity to provide proof why the additional overnight respites were necessary. The Appellant's witness failed to establish medical necessity for additional overnight respites.

The policy quoted above states in pertinent part: 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.

The CMH must authorize Respite services in accordance with the CFR and state policy. The policy in the Medicaid Provider Manual is clear that respite hours are to be provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family/primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. The Respondent's witness has demonstrated that the [redacted] overnight respites are reasonably sufficient to meet the family's need for an intermittent break from providing care for the Appellant. Accordingly, the Appellant has not proven by a preponderance of the evidence that the additional overnight respites previously authorized should remain in effect. The preponderance of the evidence demonstrates that CMH followed Medicaid policy when it reduced Appellant's respite care services effective [redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that CMH acted properly when it reduced Appellant's respite care services.

IT IS THEREFORE ORDERED that:

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

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed [redacted]

WDB/db

cc: [redacted]

***** 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.