**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.** 2011-53021 CMH
**Case No.** 88961557

**Appellant**
_____/

## 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 Thursday, [redacted]. [redacted], Appellant's grandfather/guardian, appeared and testified on behalf of the Appellant. [redacted], Appellant's Case Manager also appeared as a witness for the Appellant

[redacted], Due Process Hearings Coordinator, appeared and testified on behalf of [redacted] County Community Mental Health (CMH or the Department). [redacted], Utilization Management Coordinator, appeared as a witness 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. The Appellant is a Medicaid beneficiary who is currently receiving Medicaid covered specialty mental health services and supports of Supports Coordination, Medical Reviews, Family Training, and Respite Care Services through [redacted] County Community Mental Health (CMH). (Exhibit 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.

3. The Appellant is a [redacted] year old Medicaid beneficiary whose date of birth is [redacted]. (Exhibit 2, p. 1, Testimony). The Appellant is developmentally disabled, and is in treatment for substance abuse. (Exhibit 2, p. 3).

4. The Appellant lives in the family home with his grandfather/legal guardian, his grandmother, his mother and an aunt. (Exhibit 2, p. 1).

5. Appellant's grandfather is his primary caregiver. (Exhibit 2, p. 1, 3).

6. Appellant attends school 8 hours per day, and is supposed to go every day. (Exhibit 2, p. 3, Testimony).

7. On or about [redacted], a formal request was made to the CMH for 40 hours per month of respite. On [redacted], the CMH conducted a Respite Assessment. As a result of the Assessment, Appellant's grandfather was approved for 10 hours of respite per month. (Exhibit 2, pp. 1-5).

8. On [redacted], CMH sent an Adequate Action Notice to the Appellant's grandfather notifying him that the request for 40 hours per month of respite was denied, but that 10 hours of respite per month were approved effective [redacted]. Medical necessity not met for additional hours. The notice included rights to a Medicaid fair hearing. (Exhibit 3, pp 6-8).

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

## 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.*

CMH witness [redacted], Utilization Management Coordinator and Limited Licensed Psychologist, explained the assessment for respite care services is done at the time of the individual planning meeting. Thereafter, it is received by Utilization Management

and the Utilization Management Coordinators do the scoring based on the case manager's respite assessment.

[redacted] stated the Department does not provide a screening tool for respite care so the CMH had to develop its own screening tool. The scoring tool allows them to translate the information on the respite assessment into the number of respite hours needed in that case. She stated the case managers who do the respite assessments are not given the scoring tool so they can not manipulate the assessment to affect the number of respite hours to be approved. They are simply charged with obtaining accurate information from the client when filling out the respite assessment.

[redacted] noted that their scoring tool had changed in the past year. Under the prior scoring tool, there was a threshold of 20 hours, everyone started at 20 hours respite per month. [redacted] stated [redacted] County realized they were an outlier compared to other counties in the State and they decided to review their tool and their scoring. They eliminated their threshold and now everyone starts at zero. [redacted] also stated that they clarified the behavioral section to remove the subjectivity from the scoring and eliminated variability in the scoring. [redacted] stated that in her professional opinion the scoring tool now being used by the CMH accurately reflects the client's needs for respite services.

[redacted] reviewed Appellant's Respite Assessment. (Exhibit 2, pp.1-5) She testified that according to their scoring tool, Appellant was awarded 2 respite hours because Appellant's primary caregiver has a health condition that interferes with the provision of care, 1 respite hours because Appellant is verbally abusive on a weekly basis, 2 respite hours because Appellant engages in property destruction or disruption on a weekly basis, and 1 respite hour because he wanders on a weekly basis. [redacted] testified Appellant was also awarded 2 respite hours because he requires reminding for oral care, and 2 respite hours because she requires reminding for bathing; for a total of 10 respite hours per month.

[redacted] testified that she referred to the Medicaid Provider Manual policy section for determination of medical necessity. (Exhibit 4, pp. 9-11). She completed the adequate action notice that was sent to the Appellant on June 15, 2011. On the notice she marked a denial of service to a current consumer. She indicated 10 respite hours per month were approved of the 40 requested. [redacted] stated on the form that medical necessity was not met for the additional hours requested.

[redacted], Appellant's grandfather and legal guardian, testified Appellant was 17 years old and lives with him. He stated the Appellant attends school and is supposed to go every day. [redacted] stated the Appellant engaged in drug abuse. [redacted] stated they cut the respite time in half and that is not enough time. Appellant is worse than he ever was. [redacted] believes he needs a 3 hour break on Saturdays to get a rest and get away from the family.

[redacted] Appellant's case manager testified that the grandparents were disappointed with the decision to approve only 10 hours of respite care. [redacted] stated the grandfather is the Appellant's legal guardian. He struggles taking care of his wife, her two adult daughters and the Appellant. [redacted] acknowledged that she completed the respite assessment and that the information contained on the form was accurate.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its 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.
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> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 117.*

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 Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

> **2.5.B. DETERMINATION CRITERIA**
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> 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.

*Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, July 1, 2011, p. 13.*

Applying the facts of this case to the documentation in the respite assessment supports the CMH position that the Appellant's grandfather's respite needs could be met with the 10 respite hours per month authorized. His own testimony that he needs 3 hours on Saturdays does not come close to the 40 hours of respite per month that are being requested.

The Medicaid Provider Manual explicitly states that recipients of B3 supports and services, the category of services for which Appellant is eligible, is 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.
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> *MPM, Mental Health and Substance Abuse Section, July 1, 2011, Page 104*

A review of the Medicaid Provider Manual supports the CMH 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 Appellant's family would provide care for the period of time proposed by the CMH without use of Medicaid funding.

This administrative law judge must follow the CFR and the state Medicaid policy, and is without authority to grant respite hours not in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy in not authorizing respite other than to provide temporary relief for the Appellant's grandfather. Further, the administrative law judge is limited to making a decision based on the information the CMH had at the time it decided to authorize the Appellant's services at 10 hours of respite per month. The Appellant, who bears the burden of proving by a preponderance of evidence that there was medical necessity for the additional hours of respite requested, did not meet that burden.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the 10 respite hours per month approved for Appellant's grandfather are appropriate.

**IT IS THEREFORE ORDERED** that:

The CMH decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
Michigan Administrative Hearing System
for Olga Dazzo, Director
Department of Community Health

cc: [redacted]

Date Mailed: 10/24/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.