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. 2012-1133 CMH
Case No. 38182470

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 et seq., 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 behalf of Appellant. [redacted], Manager of Due Process, appeared and testified on behalf of [redacted] County Community Mental Health (CMH). [redacted], Manager of Utilization Management, appeared as a witness for the CMH.

Following the hearing, the record was left open and Appellant's representative was given until [redacted], to submit a copy of a behavioral plan in place for Appellant. The CMH also had until [redacted], to file a response to that plan. On [redacted], Appellant's representative sent in a letter stating that there was no such behavioral plan in place for Appellant. (Exhibit 3). On [redacted], the CMH confirmed that it did not have a copy of any behavioral plan. (Exhibit 4).

ISSUE

Did the CMH properly deny Appellant's request for 40 hours of respite care services per month and instead authorize 21 hours of such 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. Appellant is a [redacted] year-old boy who has been diagnosed with attention deficit hyperactivity disorder (ADHD). His mother also reports "lots of hyperactivity, severe mood swings, aggressive to others, [and] oppositional behavior." (Exhibit 1, pages 1, 3). Appellant lives in the

family home with his mother and she is his primary caregiver. (Exhibit 1, page 3; Testimony of [redacted]).

2. The 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. Appellant has been receiving 40 hours of respite care services per month through the CMH for over a year. Appellant's mother also receives an adoption subsidy through the State of Michigan. (Exhibit 1, page 2; Testimony of [redacted]).

4. On [redacted], the CMH conducted a Respite Assessment. (Exhibit 1, pages 1-5). Appellant's mother/representative again requested 40 hours of respite care per month. (Testimony of [redacted]; Testimony of [redacted]).

5. Based on that assessment and the scoring tool used by the CMH, the CMH authorized 21 hours of respite care per month. (Testimony of [redacted]).

6. On [redacted], the CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the request for 40 hours per month of respite was denied, but that 21 hours of respite per month were approved effective [redacted]. (Exhibit 1, pages 6-8).

7. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 2).

8. During the hearing, the CMH's representative stated that, based on the testimony presented, it would increase Appellant's respite care by another 4 hours per month. (Testimony of [redacted]).

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 C.F.R. § 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 C.F.R. § 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…
>
> (42 U.S.C. § 1396n(b)

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. With respect to respite care services, it states:

> **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.
>
> *(MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 118)*

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the MI Choice waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230. The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits:

> **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; 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.

(*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 13)*

In addition to requiring medical necessity, the MPM also states that B3 supports and services, such as respite care services, are 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, October 1, 2011, page 105)*

Here, applying the relevant policy and facts in this case, the CMH's decision to deny the request for 40 hours of respite care services per month and only authorize of 21 hours of respite care services per month must be sustained as it is reflective of the need for assistance and provides Appellant's mother with significant, temporary relief.

CMH witness [redacted], Manager of Utilization Management Coordinator, testified that staff from Child and Family Services meet with the parent(s) and fill out the respite assessment. Thereafter, Utilization Management receives a request for authorization along with the respite assessment. Utilization Management Coordinators apply their scoring tool and assign respite hours based on the respite assessment.

[redacted] also testified that the Department does not provide a screening tool for respite care so the CMH has developed its own screening tool. He stated the authorization of respite care according to the Medicaid Provider Manual is based on the documentation in the clinical records in order to insure that the authorization meets the requirements of medical necessity. [redacted] also stated the clinicians who do the respite assessments are not given the scoring tool so they cannot manipulate the answers on the assessment and 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] further noted that the scoring tool had changed in the past year. Under the prior scoring tool, there was a starting point of 20 hours of respite care per month, which has been eliminated. According to the CMH's witness, it also clarified the behavioral section to remove the subjectivity from the scoring and achieved more accurate and uniform scoring within their department. [redacted] testified that, in his professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services.

[redacted] also reviewed Appellant's Respite Assessment during the hearing. He testified that, according to the scoring tool, Appellant was awarded 6 respite hours because Appellant's only caregiver, his mother, works full-time, 2 respite hours because Appellant's mother's lupus interferes with the provision of care, 2 respite hours because there was an average of 1-2 interventions per night, 1 respite hour because Appellant is verbally abusive weekly, and 1 respite hour because Appellant has a temper tantrum weekly.

[redacted] also testified Appellant was awarded 3 respite hours because Appellant requires assistance with self care-oral care, 3 respite hours because Appellant requires assistance with bathing, and 3 respite hours because Appellant requires assistance with toileting,

[redacted] further testified that he referred to the Medicaid Provider Manual policy section for determination of medical necessity. He noted that the policy allows a PIHP to employ various methods in order to determine the amount scope and duration of services, including respite services. [redacted] testified that respite services are to provide

a temporary break for an unpaid caregiver; it is not intended to be provided on a continuous or daily basis.

Appellant's representative/mother testified that 21 hours are insufficient and that she was a better caregiver when receiving 40 hours of respite care. With respect to the specific criteria, she also testified that she disagreed with three of the findings in the assessment. According to Appellant's mother, Appellant is verbally abusive daily, not weekly, and he does require assistance with self care-eating. However, Appellant's mother does not remember what she told the worker completing the assessment regarding those two issues. Appellant's mother also testified that Appellant has a behavioral plan in place.

In response to that testimony, which it characterized as new, the CMH decided to grant Appellant an additional 4 hours of respite care, effective immediately. (Testimony of [redacted]). One additional hour was added to due to the change from weekly verbal abuse to daily verbal abuse while 3 additional hours were added due to Appellant requiring some assistance with self care-eating. (Testimony of [redacted]).

The CMH's representative also testified that, if Appellant's mother could produce a behavioral plan, it would authorize an additional 10 hours of respite care. (Testimony of [redacted]). This Administrative Law Judge left the record open following the hearing so that Appellant's mother could provide a copy of Appellant's behavioral plan. However, Appellant's mother subsequently provided a letter stating there was no such plan. (Exhibit 3).

In total, Appellant will now receive 25 hours of respite care. However, while the CMH will increase the respite hours in light of new information, its previous decision must still be affirmed based on the information available at the time.

Appellant bears the burden of proving by a preponderance of evidence that there was medical necessity for the additional hours of respite requested. Here, Appellant did not meet that burden of proof. The CMH adequately explained what led to a decrease in Appellant's respite hours and how it calculated the number of respite hours that are medically necessary. It also provided evidence that it adhered to the relevant regulations and state policy by not authorizing respite other than to provide temporary relief for the Appellant's mother. Appellant's representative argues that Appellant's needs have not changed, but this Administrative Law Judge must follow the Code of Federal Regulations and the state Medicaid policy, and is without authority to grant respite hours not in accordance with those regulations and policies. Accordingly, the CMH's decision must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the 21 hours of respite care per month approved for Appellant is proper based on the information available at the time.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Steven Kibit
Administrative Law Judge
Michigan Administrative Hearing System
for Olga Dazzo, Director
Department of Community Health

cc: [redacted]

Date Mailed: 12/6/2011