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. 2012-24643 CMH
Case No. [redacted]

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 [redacted]. [redacted], Appellant's Case Manager with [redacted], appeared and testified on behalf of the Appellant. Appellant's mother [redacted] also testified on behalf of the Appellant.

[redacted], Manager of Due Process, appeared on behalf of [redacted] (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 services and supports of Supports Coordination, and Respite Care Services through [redacted] (CMH) as B3 services. (Exhibit 1 and 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]. The Appellant has diagnoses of pervasive development disorder, mental retardation, scoliosis, Rhett's syndrome, seizure activity, and chronic constipation. (Exhibits 2, 5, 11 and testimony).

4. Appellant's mother is her guardian and primary caregiver. (Exhibits 2, 5).

5. Appellant attends SRESA in [redacted], but is only able to attend approximately 3 days per week from 10:30 a.m. to 3:30 p.m. (Exhibit 5 and testimony).

6. On or about [redacted], a formal request was made to the CMH for 96 hours per month of respite. On [redacted], a respite assessment was conducted. The respite assessment was scored by the Utilization Management Department and as a result Appellant's mother was approved for 53 hours of respite per month. (Exhibits 1 & 2).

7. On [redacted], CMH sent an Adequate Action Notice to the Appellant's mother notifying her that 53 hours of Respite per month of the 96 hours requested were approved effective [redacted]. Medical necessity not met for additional hours. The notice included rights to a Medicaid fair hearing. (Exhibit 3).

8. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 13).

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 along with a request for authorization of respite care and the Utilization Management Coordinators use their scoring tool to score out the hours of respite to be authorized. The authorization is based on documentation from the Appellant's electronic medical records as required by the Medicaid policy for determining medical necessity.

[redacted] reviewed Appellant's Respite Assessment and her IPOS. (Exhibit 2) She testified that according to their scoring tool, Appellant was given 4 respite hours because there is one caregiver in the home one who is working full time, 4 respite hours were also given because there is an average of 3 or more interventions per night, 3 respite hours were given because Appellant is physically abusive to others daily, and 3 respite hours were given because Appellant is physically abusive to herself daily.

[redacted] testified Appellant was also given 4 respite hours because Appellant requires total assistance with mobility, 4 respite hours were given because Appellant requires total assistance with oral care, 4 respite hours were given because Appellant requires total assistance with eating, 4 respite hours were given because Appellant requires total assistance with bathing, 4 respite hours were given because Appellant requires total assistance with toileting, and 4 respite hours were given because Appellant requires total assistance with dressing.

[redacted] further testified that 3 respite hours were given because Appellant requires food to be in mashed or ground so she can be fed orally, 4 respite hours were given because Appellant requires total assistance with grooming, and 3 respite hours because Appellant is over 18 and requires medication to be administered to her; for a total of 48 respite hours per month. [redacted] said 2 respite hours were added because Appellant is nonverbal and 3 more were added as Appellant needs extensive prompting and encouragement for participation.

[redacted] stated a total of 53 respite hours per month were authorized for the Appellant's mother. On [redacted] she sent an Adequate Action Notice to the Appellant's mother notifying her that 53 hours of Respite per month of the 96 hours requested were approved effective [redacted]. Medical necessity not met for additional hours.

[redacted] testified that she referred to the Medicaid Provider Manual policy section for determination of medical necessity. She further noted the policy allows a PIHP to employ various methods in order to determine the amount scope and duration of services, including respite services. Appellant's services were being provided as B3 services. She further stated that respite services are to provide a temporary break for an unpaid caregiver, they must consider the capacity to serve others and such services are not intended to meet all the needs of the Appellant. (Exhibit 4).

[redacted] stated CMH uses a scoring tool for respite care. [redacted] noted that their scoring tool had changed in the past year. [redacted] stated [redacted] realized they were an outlier in the State in the amount of respite they were authorizing. [redacted] stated they clarified the behavioral section to remove the subjectivity from the scoring and eliminated variability in the scoring. Under their prior scoring tool, there was a threshold of 20 hours, which has now been eliminated and the hours redistributed to allow for a maximum of 96 hours on the scoring tool.

[redacted], Appellant's case manager with CMH testified she became Appellant's case manager in [redacted] and did the respite assessment on [redacted]. [redacted] believed the assessment was the same as the prior assessment done on [redacted], but it resulted in a reduction in the number of respite hours.

[redacted] stated the new scoring tool is supposed to be objective, but this shows there is still subjectivity in the scoring. When confronted with the two assessments, [redacted] acknowledged that the assessments were not identical. (See Exhibits 2 & 8). Further, Appellant was now receiving additional services such as home help that she wasn't receiving in [redacted]

[redacted], Appellant's mother and guardian, testified Appellant had grand mal seizures for 16 months and has returned to tube feeding. [redacted] stated she wants the respite hours increased because she is a single parent. Appellant's seizures are back, and due to her condition Appellant does not attend school daily. [redacted] stated her daughter is a lot of work and believes she will have to put her in a home if her respite is not increased.

[redacted] stated her mother, Appellant's grandmother, is her respite worker. Her mother comes every day even if not paid for it. [redacted] acknowledged the Appellant is getting Home Help from DHS. [redacted] is the paid worker and receives about [redacted] per month at [redacted] per hour for providing the home help services.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to B3 supports and services including Respite Care:

> **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.
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> * * *

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.

* * *

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).

  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.

Medicaid Provider Manual, Mental Health and Substance Abuse Section, January 1, 2012, pp. 105-106, 118-120.

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**
>
> 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, October 1, 2011, p. 13.

Applying the facts of this case, including the documentation contained in the respite assessment, supports the CMH position that the Appellant's mother's respite needs could be met with the 53 respite hours per month authorized. The testimony of the Appellant's mother and case manager did not change the result. The scoring of the January respite assessment demonstrates that the Appellant's mother's needs for respite can reasonably be met by the 53 hours authorized. Appellant's grandmother is

providing additional natural supports beyond the respite care she is being paid to provide. Furthermore, respite is not available when Appellant's mother is being paid to provide the Home Help services.

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 a portion of the day without use of Medicaid funding. Furthermore, according to Medicaid policy respite is not available when the family member is being paid to provide the home help service.

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 a temporary break for the Appellant's mother. 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 53 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 53 respite hours per month approved for Appellant's mother 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: 2/28/2012

***** 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.