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:

Docket No. 2012-39326 CMH

[redacted],

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on behalf of Appellant. [redacted], Manager of Due Process, appeared on behalf of the Genesee County Community Mental Health (CMH). [redacted], Care Coordinator in the Utilization Management Department, appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for 60 hours of respite care services per month and instead authorize 23 (later 24) 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 male who has been diagnosed with ADHD and anxiety disorder. Appellant is also physically handicapped and unable to walk. (Exhibit 1, page 17).

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 had been receiving 60 hours of respite care services per month through the CMH. (Testimony of Mercer).

4. On [redacted], the CMH conducted another Respite Assessment. (Exhibit 1, pages 1-4). Appellant's mother again requested 60 hours of

respite care per month. (Exhibit 1, page 2).

5. Based on the assessment and the scoring tool used by the CMH, the CMH found that 23 hours of respite care per month were medically necessary. (Testimony of Dahl).

6. On [redacted] the CMH sent notice to Appellant notifying him that the request for 60 hours per month of respite was denied, but that 23 hours of respite per month were approved effective [redacted] (Exhibit 1, pages 5-7).

7. The Michigan Administrative Hearing System (MAHS) received a complete Request for Hearing by Appellant on [redacted]. (Exhibit 2, page 1).

8. Subsequently, an error in the authorization of Appellant's respite hours was discovered and the CMH's representative testified that 24 hours of respite care services per month would be authorized, effective the day of the hearing. (Testimony of Dahl; 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 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…
>
> (42 USC 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.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section, articulates the relevant policy and, with respect to respite care services, it states:

> **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.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)

- Home of a friend or relative chosen by the beneficiary and members of the planning team

- Licensed camp

- In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MRs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

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.

(MPM, Mental Health and Substance Abuse Section, January 1, 2012, pages 118-120)

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230. Regarding medical necessity, the MPM provides:

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

(MPM, Mental Health and Substance Abuse Section, January 1, 2012, pages 12-13)

The MPM also describes the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits as medically necessary:

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, January 1, 2012, 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.
>
> (MPM, Mental Health and Substance Abuse Section, January 1, 2012, page 106)

Here, CMH witness [redacted] Care Coordinator for the Utilization Management Section of the CMH, testified regarding the assessment and allocation of respite hours in this case. [redacted] testified that MDCH does not provide a screening tool for respite care, so the CMH has developed its own tool that is only used in Genesee County. According to [redacted] staff from Child and Family Services meets with the parent(s) and fills out the respite assessment form. However, in conducting the respite assessment, the staff that complete the respite assessments are not given the scoring tool so they cannot manipulate the answers on the assessment or affect the number of respite hours to be approved. Those clinicians are simply charged with obtaining accurate information from the client when filling out the respite assessment. Subsequently, Utilization Management receives a request for authorization, along with the respite assessment, and Utilization Management Coordinators apply a scoring tool and assign respite hours based on the respite assessment.

[redacted] further testified that the scoring tool was changed in the past year in part because the CMH was an outlier in awarding respite hours and the old scoring tool was deemed too subjective. For example, the starting point of 20 hours of respite care per month under the prior scoring tool has been eliminated. Another change was to clarify the behavioral section in order to remove the subjectivity from the scoring and achieved more accurate and uniform scoring within their department. [redacted] also testified that, in her professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services.

[redacted] was not the initial scorer of Appellant's respite assessment. However, she also testified that she agreed with the initial score, with one exception. The exception will be identified below.

With respect to Appellant's score, [redacted] testified that, according to the scoring tool, Appellant was awarded 4 respite hours per month because he has two or more caregivers who both work or are in school fulltime and 2 respite hours because he has 1-2 interventions per night or the time required to complete the intervention is less than an hour. [redacted] also testified that, per the scoring tool, Appellant was awarded 1 respite hour per month because he has weekly temper tantrums.

[redacted] further testified Appellant was awarded 3 respite hours per month for mobility because Appellant requires physical assistance with transfers, 3 respite hours because he requires physical assistance with self care-oral care, 2 respite hours because Appellant is independent after set up with respect to self care-eating, 3 respite hours because Appellant requires assistance with self care-bathing, 4 respite hours because Appellant requires total physical assistance with self care-toileting, and 2 respite hours because Appellant requires reminding for self care-dressing.

The respite hours identified above total 24 respite hours per month. However, as testified to by [redacted], the original scorer miscalculated the Appellant's score and only authorized 23 hours per month. The CMH's representative subsequently stated that 24 respite hours per month would now be authorized, effective the date of the hearing.

According to [redacted] if anything in the "other clinical needs" section justifies additional respite hours, then the scorer could contact the scorer's supervisor and have additional hours awarded. No such hours were awarded in this case. According to [redacted] everything discussed in that section was covered by other areas.

[redacted] further testified that she referred to the Medicaid Provider Manual policy section for determination of medical necessity. She 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] also testified that respite services are to provide a temporary break for an unpaid caregiver and are not intended to be provided on a continuous or daily basis.

Appellant's mother testified that 24 hours of respite care per month is not a great help to her and Appellant's other caregivers. In particular, Appellant's mother noted that, given Appellant's difficulties and medical needs, the respite worker cannot be left alone with Appellant. Appellant's mother further testified that Appellant's respite hours have been cut significantly during the last two assessments event though Appellant's needs have not changed.

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. While Appellant's mother described his significant needs, those needs were expressly accounted for in the respite assessment form. Appellant's mother did not disagree with answers found on that form or identify any other issues unaccounted for. 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. In particular, its witness described how changes in the respite assessment process could lead to a decrease in service despite a client's condition remaining the same. The CMH also provided evidence that it adhered to the relevant regulations and state policy by not authorizing respite other than to provide temporary relief for Appellant's caregivers. Similarly, 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.

Applying the relevant policy and facts in this case, the CMH's earlier decision to deny the request for 60 hours of respite care services per month and only authorize of 24 hours of respite care services per month must be sustained as it is reflective of the need for assistance and provides Appellant's caregivers with significant, temporary relief.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly authorized 24 hours of respite care per month for Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-16-12

***** 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.