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. 2012-5579 CMH
Case No. 31468162

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 father, appeared and testified on behalf of the Appellant. [redacted], Appellant's Case Manager, in Case Management and Supports Coordination with the CMH also testified on behalf of the Appellant. Appellant [redacted] was also present at the hearing.

[redacted], Manager of Due Process, appeared on behalf of [redacted] County Community Mental Health (CMH or the Department). [redacted], LMSW, a Care Coordinator with the Utilization Management Department for the CMH, 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 Coordination, Community Living Supports, Occupational Therapy Services, 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]. The Appellant is diagnosed with severe mental retardation, cerebral palsy, and attention deficit disorder. (Exhibits 2 & 5, and Testimony).

4. The Appellant lives in the family home with her father. Appellant's father is her guardian and primary caregiver. (Exhibit 5 and Testimony).

5. On [redacted], a formal request was made to the Utilization Management Department for the authorization of Respite services in the amount of 66 hours per month. The CMH conducted a Respite Assessment and determined that the Appellant met the medical necessity for 48 hours per month. (Exhibits 1 & 2 and Testimony).

6. On [redacted], CMH sent an Adequate Action Notice to the Appellant's father notifying him that the request for 66 hours per month of respite was denied, but that 48 hours of respite per month were approved effective [redacted]. The notice included rights to a Medicaid fair hearing. (Exhibit 3).

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

8. A subsequent review of the scoring of the Respite Assessment indicated a calculation error and the authorization for Respite Care was changed to 50 hours per month. (Exhibit 1 and Testimony).

9. During the administrative hearing, additional information came to light concerning the Appellant's need for assistance in eating and the caregiver's medical condition that is interfering with his ability to provide care, which caused the Department to increase the number of respite hours to 54 per month effective [redacted]. (Testimony)

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.
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> *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], LMSW, explained the process for approving respite care starts with the Case Manager filling out the respite assessment. Then the Case Manager, in this case [redacted], makes a request for authorization. Thereafter, a Care Coordinator for the CMH uses their scoring tool to determine the appropriate number of respite hours needed based on the respite assessment.

[redacted] stated the Department does not provide a screening tool for respite care so the CMH created its own screening tool. She stated the authorization of respite care according to the Medicaid Provider Manual is based on the documentation in the Appellant's clinical records. [redacted] stated the case managers 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.

[redacted] noted that their scoring tool had changed in the past year to eliminate the previous threshold of 20 hours. The number of hours approved are based on the behavioral and self care needs of the Appellant. The CMH clarified the behavioral section in their respite assessment to remove the subjectivity from the scoring in the behavioral section and to come up with an objective scoring tool for determining the need for respite care.

[redacted] reviewed Appellant's Respite Assessment and the scoring that was done by [redacted], LLP, another Care Coordinator for the CMH. (Exhibit 2) She testified that according to their scoring tool, Appellant was awarded 6 respite hours because Appellant's primary caregiver was working full-time, 4 respite hours as there was an average of 3 or more interventions per night, 2 respite hours because Appellant is physically abusive to others weekly, and 2 respite hours because Appellant was physically abusive to herself weekly.

[redacted] testified Appellant was also awarded 3 respite hours because Appellant needs assistance with transfers, 4 respite hours because Appellant needs total assistance for oral care, 2 respite hours because Appellant eats independent after set up, 4 respite hours because Appellant requires total assistance with bathing, 4 respite hours because Appellant needs total assistance with toileting, and 4 respite hours because Appellant needs total assistance with dressing. [redacted] further testified Appellant was awarded 3 respite hours for her dietary needs, i.e. texture modification. [redacted] testified Appellant was awarded 4 respite hours because Appellant needs total assistance with grooming, 3 respite hours because Appellant needs medication assistance and is over age 18, 2 respite hours because Appellant is non-verbal, and 3 respite hours because for Appellant to participate she requires extensive prompting and encouragement.

[redacted] indicated that [redacted] came up with 48 respite hours when she scored the assessment. However, after a review of the scoring it was determined that a mistake was made in the initial calculation and that 2 hours were missed. A subsequent authorization was made for 50 hours per month of respite care.

[redacted] testified that they refer 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. [redacted] stated 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. (Exhibit 4).

[redacted], Appellant's father, testified he is the Appellant's primary caregiver. He testified he requested that they keep the respite hours at 66 hours as previously authorized. [redacted] testified his daughter requires assistance with eating beyond set up and he actually has to feed her in the morning with the time allowed before she goes to school. She attends school five days per week, leaving between 7:10 a.m. and 7:15 a.m. each day and returning by 2:45 p.m. He stated the Appellant needs constant attention.

[redacted] stated with 66 hours he would have additional time to work and supplement his pension. He stated while his wife was still alive they never had to ask for these services, but after her death he was just lost. [redacted] stated the Appellant also receives 10 hours of CLS per week. He uses his respite hours five days per week. He stated the Appellant does not receive Home Help through DHS.

[redacted] Appellant's Case Manager testified he agreed with [redacted] that the respite hours should stay at 66 hours per month. He acknowledged he completed the respite assessment and believed it was accurate when done on [redacted]. He stated he would change the assessment based on [redacted] testimony concerning the further assistance needed by Appellant for eating and due to [redacted] psychological condition with the added stress he is experiencing trying to care for the Appellant. [redacted] stated he had not considered Home Help for the Appellant.

At the conclusion of the hearing the Department's representative, [redacted], indicated based on the testimony at the hearing the Department was going to increase the respite hours to 54 hours per month effective [redacted]. [redacted] stated Appellant would be given 2 more hours due to needing assistance beyond set up for eating and 2 more hours for the caregiver having a condition which was interfering with his ability to care for his daughter the Appellant.

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, October 1, 2011, Page 118.*

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:
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> - 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 to the documentation in the respite assessment supports the CMH position that the Appellant's father's respite needs could be met with the 54 respite hours per month that are being authorized.

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, October 1, 2011, Page 105*

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 father. 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 50 hours of respite per month.

The Department has shown that it consistently follows policy when it authorizes respite hours, by the fact that the number of hours was increased on the day of the hearing, based on testimony justifying the additional hours. The Appellant bears the burden of proving by a preponderance of evidence that there was medical necessity for the 66 hours of respite requested, but based upon the evidence presented at the hearing the Appellant 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 54 respite hours per month approved for Appellant's father 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: 12/14/2011

***** 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.