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],

Appellant

_____/

Docket No. 2012-9327 CMH
Case No. 9519168

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]. Appellant's parents, [redacted] and [redacted], appeared and testified on behalf of Appellant. [redacted], Manager of Due Process, appeared on behalf of the [redacted] County Community Mental Health (CMH). [redacted], Care Coordinator for Utilization Management, appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for 50 hours of respite care services per month and instead authorize 30 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 Asperger's Pervasive Developmental Disorder. (Exhibit 1, page 3).

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 50 hours of respite care services per month through the CMH. (Exhibit 1, page 2).

4. On [redacted], the CMH conducted another Respite Assessment. (Exhibit 1, pages 1-5). Appellant's parents again requested 50 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 only authorized 30 hours of respite care per month. (Testimony of [redacted]).

6. On [redacted], the CMH sent notice to Appellant notifying him that the request for 50 hours per month of respite was denied, but that 30 hours of respite per month were approved effective [redacted]. (Exhibit 1, pages 6-8).

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

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.

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**
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> 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 Specialty Services and Support program 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**
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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.
>
> (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.
>
> *(*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 50 hours of respite care services per month and only authorize of 30 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.

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. Holiday 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 [redacted] 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 his professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services.

According to [redacted], she reviewed Appellant's Respite Assessment, but she was not the original scorer. However, she also stated that she would have score the same amount of respite hours had she been the original scorer.

With respect to Appellant's score, [redacted] testified that, according to the scoring tool, Appellant was awarded 4 respite hours per month because Appellant's has two or more caregivers, both of whom work or are in school full-time or part-time, and 2 respite hours because there are 1-2 interventions per night taking 1 hour or less.

[redacted] also testified that, per the scoring tool, Appellant was awarded 2 respite hours per month because he is verbally abusive daily, 3 respite hours because he is physically abusive to others daily, 2 respite hours because he engages in property destruction/disruption of property weekly, 1 respite hour because he has temper tantrums daily, and 2 respite hours because he wanders daily.

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

As stated in [redacted] testimony, Appellant was also awarded 4 respite hours per month because he requires total assistance with grooming and 3 respite hours because he requires extensive prompting and encouragement in the area of participation.

[redacted] also testified that the narrative sections of the respite assessment form are reviewed and taken into consideration when allocating hours. If anything in the narrative justifies additional respite hours, then the scorer could contact the scorer's supervisor and have additional hours awarded. The scoring tool allows for 13 such discretionary hours. No such hours were awarded in this case.

[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.

In their testimony, Appellant's mother testified that Appellant received 50 hours of respite care services per month last year and that she and her husband used every hour authorized. [redacted] also testified that Appellant's behavior has only worsened. For example, Appellant will now react to bad weather with temper tantrums and his behavior toward his sister has become abusive. However, both those new developments were discussed in the narrative section of the form and accounted for in the hours awarded for temper tantrums or physical abuse to others.

Moreover, Appellant's parents also disputed some of the specific answers on the respite assessment form. For example, [redacted] testified that her husband has a back injury that interferes with Appellant's care. [redacted] also testified that Appellant requires reminders with respect to tasks such as self care-toileting and self care-dressing. However, both [redacted] and [redacted] testified that they do not recall what they told the staff member completing the respite assessment form. The CMH's decision must be reviewed in light of the information available at the time of the decision and it relies on the parents and staff to provide complete and accurate answers. Here, given the lack of testimony regarding what the CMH staff was told, there no basis for reversing its decision.

Similarly, while [redacted] testified that they are in the process of getting a behavior plan for Appellant, which would increase the number of the respite hours, it is undisputed that no behavior plan was in place at the time of the CMH's decision. Accordingly, the decision not to award hours for that factor must be affirmed. If Appellant's situation changes, he can always apply for more hours.

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 Appellant's parents. Appellant's representatives argues that Appellant's needs have only worsened, 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, decides that the 30 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 decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 12/27/2011

***** 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.