STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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. 2009-31005 CMH

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented the Appellant. [redacted] was present and testified on behalf of the Appellant.

[redacted], appeared for the Respondent. [redacted], was present on behalf of [redacted] (hereinafter [redacted] or Department). [redacted] or Department) and [redacted] are representatives of the Department of Community Health, as agencies contracted with the Department of Community Health to provide Medicaid-funded mental health managed specialty supports and services.

ISSUE

Has the Department properly denied the Appellant's request for 12 respite hours per week and 24 overnights per year respite services?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is an [redacted] Medicaid beneficiary. He is autistic and has a heart condition as well. He resides with his family in the family home and attends school full time. (uncontested testimony from the Appellant's mother)

2. The Appellant is non-verbal. He has sensory integration needs that require daily brushing therapy. He exhibits mild PICA behavior. He can be aggressive when

agitated. He becomes agitated on a daily basis. (Department Exhibit A, pages 9, 18, 21, 22 and testimony from the Appellant's mother)

3. The Appellant's aggressive behaviors include striking, scratching, pulling, grabbing, throwing toys that have and do strike other family members, pushing, pinching, property destruction and physical resistance. He can be self injurious. (Department Exhibit A, pages 9, 18, 21, 22 and testimony from the Appellant's mother)

4. The Appellant requires hands on assistance with all activities of daily living and instrumental activities of daily living, including dressing, bathing, grooming, toileting, meal preparation, medication and housework. He is incapable of caring for himself with only monitoring and supervision. (uncontested testimony of the Appellant's mother)

5. The Appellant lives with his family, which includes 4 additional siblings ranging in age down to [redacted] old. He resides with both parents. His mother works full time. His father does not work outside the home at this time. (Department Exhibit A, Appellant's IPOS)

6. The Appellant's behavior at school and with his primary paid care taker is less aggressive and agitated than in his own home. (uncontested testimony from the Appellant's mother and paid care taker)

7. The Appellant attends school 180 days per year. (stipulated at hearing through testimony of the Appellant's mother and [redacted] witness)

8. The Appellant's most recent Individual Plan of Service contains authorization for respite in the amount of 6 hours per week and 14 overnight periods per year. (uncontested)

9. The Appellant requested, through the Appellant's supports coordinator, respite services for 12 hours per week and 24 overnight periods for the year long authorization period. (uncontested)

10. The Respondent completed a respite assessment, in order to evaluate the Appellant's caregivers' need for respite. The internal guidelines resulted in a recommendation for respite that was not implemented by [redacted]. The amount recommended by the guidelines was not put into evidence at hearing. (uncontested)

11. The Department denied the requested amount of respite services citing lack of medical necessity and further citing receipt of other services the Appellant receives, Community Living Supports (CLS) and Adult Home Help Services. (uncontested testimony of [redacted] witness)

12. An internal appeal was filed. The result of the internal appeal was that the authorizing agency was ordered to do another respite assessment. The newly ordered re-assessment yielded the same result, 6 hours per week and 14 overnights per year.

13. A request for formal administrative hearing was received on [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…

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.

Michigan's Medicaid Prepaid Specialty Mental Health and Substance Abuse Services

combination 1915(b)(c) Medicaid Prepaid Specialty Services and Supports waiver for Persons with Developmental Disabilities or Mental Illness programs was initially approved in 1998. The Michigan program "carves out" specialty mental health, substance abuse and developmental disabilities services and supports and provides these services using a pre paid shared risk design. The program is designed to provide beneficiaries with a "person centered" assessment and planning in order to provide a broad, flexible set of supports and services.

[redacted] contracts with the Department through a Managed Specialty Supports and Services Contract (MSSSC) to provide State Medicaid Plan services to Medicaid beneficiaries who reside in their service area. Medicaid beneficiaries are entitled to services through the CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MSSSC.

2. The service in issue is a Medicaid covered service i.e. State Medicaid plan or waiver program service and

3. The service is medically necessary.

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

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.

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.

The Medicaid Provider Manual, Mental Health/Substance Abuse, October 1, 2009 sets forth policy regarding B3 services below. Respite is a B3 service.

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.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES
The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health

and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation
The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).

Independence "Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity Engaged in activities that result in or lead to maintenance of or increased self sufficiency.

Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals.

For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

Version Mental Health/Substance Abuse
Date: October 1, 2009

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.

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.

Version Mental Health/Substance Abuse
Date: October 1, 2009 Pages 110-111

The witness from [redacted] testified, in essence, that the amount of respite authorized is sufficient in amount, scope and duration to meet the Appellant's medically necessary needs. She stated additional hours are not medically necessary. She cited the Appellant's Community Living Supports (CLS) authorization as an additional service that benefits the Appellant, as well as the Adult Home Help Service hours. The case presented is that there are 168 hours in any given week and the respite guideline attempts to determine how much unpaid care the Appellant's primary caregivers are providing each week. Based upon that determination and other factors in the family circumstance, the Respite Guide helps the agency to determine how much respite is appropriate. Other considerations besides how much time is unpaid care during the week, taken from their own document include: whether the caregiver is working or in school, the health of the caregiver, other dependents in the home and amount and type of interventions performed by the caregiver. The Department witness stated the guidelines are not controlling and are not applied rigidly. She did not reveal what the Department's recommendations were based upon the Respite Decision Guide (Department Exhibit A, pages 6-7). She did concede the remainder of the document (following the 2 pages that were submitted) was not put into evidence. The remainder of the document would have contained the recommendation for respite hours based upon a score reached by completing the aforementioned sections of the worksheet.

The amount of unpaid care provided was discussed at length during the hearing. There is disagreement between the parties regarding how much unpaid care is provided. The Department witness testified the family provides approximately 24 hours per week of unpaid care to the Appellant. This was derived by starting with the 168 hours in each week and subtracting the amount of time spent being transported to/from and in school. Also subtracted is the uninterrupted sleep time, CLS provided, Home Help hours provided and other supports being provided. The Department's calculations were for 168 total hours less 144 hours of the care givers are not providing unpaid care, yielding 24 hours of unpaid care and a score of 0 for the section.

The [redacted] witness asserted the Appellant is being transported to/from and in school 40 hours per week. She made no allowance or consideration for school breaks, holidays, summer vacation, half days or sick days when the Appellant does not attend school. She stated he is in

school 9 months per year. It is undisputed he is authorized to receive 42 hours per week CLS, 10 hours per week Home Help and 6 hours respite.

The Appellant's mother stated he is actually in school 180 days, which is 6 months, not counting half days. The [redacted] witness did not dispute the Appellant has 180 days of school scheduled. She was specifically asked if she disputed this contention. She stated no. This ALJ takes official notice of the fact that 180 days is equal to 6 months, not 9.

Continuing on the unpaid care giving time worksheet, uninterrupted sleep is taken into consideration. The worksheet specifically asks for the number of hours of uninterrupted sleep and contains a parenthetical (average hours per day x 7). The Department has recorded 46 hours per week uninterrupted sleep. This was derived by taking the total sleep time reported and subtracting 3 hours per week due to the uncontested reports that the Appellant awakes during the night 4-5 times per week having wet the bed. Either his mother or father must get up for 20-30 minutes to change the bed linens 4-5 times per week in the middle of the night. The Department still calculated 6.5 hours per night of uninterrupted sleep for a total of 46 hours.

The 42 hours of CLS, 10 hours Home Help and 6 hours respite are then subtracted, leaving 24 hours of unpaid care being provided each week.

This ALJ does not agree that the number of hours of unpaid care each week is limited to 24. No consideration is given for the weeks during the year the Appellant is not at school for 40 hours. If the Appellant has 180 days of school scheduled, then he has 185 days left in the year without school. Estimating 10 weeks without school in the summer, 3 weeks for Christmas vacation and 2 weeks for other scheduled school vacations such as winter break, spring break and other less than full weeks, the Appellant has 15 weeks where he is being provided up to an additional 40 hours of unpaid care per year. There is testimony that he has had some summer school. This is not for the entire summer, nor is it 40 hours per week according to testimony taken. Even given the fact that he has some summer school, the evidence of record does indicate he has many weeks where much more than 24 hours of unpaid care is being provided.

Additionally, the calculation of uninterrupted sleep is suspect in the opinion of this ALJ. The amount of sleep is interrupted more than it is not interrupted, according to uncontested, credible testimony and documentation submitted by the Department. The documentation submitted states the Appellant is up at night 4 to 5 times per week having wet the bed. He awakes his parents. This regular schedule of sleep interruption takes a toll on a family and does not appear to be given much weight by the Agency because the calculation is for 46 hours of uninterrupted sleep. This was derived by taking the total number of hours the Appellant sleeps and adding up the amount of time spent up at night with the Appellant and subtracting it from the total sleep hours. This is not a calculation of uninterrupted sleep as much as it is a calculation of total number of hours of sleep. The calculation could have been for 2 days per week at 6 hours per night and 5 days per week of 3-4 hours per night, totaling approximately 34 hours per week rather than 46. The evidence suggests the agency scored the section in a manner so as to maximize the number of hours of sleep that is scored "against" a need for respite when calculating the number of unpaid hours of care. This ALJ noted the category called for a report regarding uninterrupted sleep, not total number of hours of sleep. The fact of sleep interruption is significant for both the physical and mental health of care providers and should be given

appropriate weight in determining respite authorizations.

Even recalculating the amount of unpaid hours of care being provided in accordance with the actual school schedule rather than disregarding the fact the Appellant has several weeks per year when not in school and reducing the hours of uninterrupted sleep recorded may not change the ultimate score derived from the respite decision guide from 14 to a higher score. It appears as if the number of hours of unpaid care must exceed 56 per week to result in a point being added to the total. This discussion of the evidence presented relative to unpaid care being provided does serve to illustrate how the Agency approached the decision and what is considered, or supposed to be considered.

There was contested testimony regarding the Appellant's behaviors, which impacts the interventions needed by the family. The Department witness, after hearing the evidence from the Appellant's mother about how aggressive the Appellant is, stated it was news to her and there was no documentation to corroborate the testimony. The Appellant's mother had testified the Appellant has thrown toys and struck other family members heads and eyes with them. He has drawn blood when scratching, striking and physically resisting attempts to control him. She read from notes she made and cited dates and specifically described his conduct that resulted in blood being drawn, a black eye, hair being pulled out of her head and physical altercations. This ALJ found the testimony from the Appellant's mother regarding these altercations credible. The fact of lack of Department documentation corroborating the incidents did not persuade this ALJ that they had not happened. The Appellant's mother specifically addressed the lack of Department documentation by testifying she had reported the incidents during the monthly in home visit from the psychologist, who had refused to take documents from her. The interventions performed by the caregivers are considered on the Respite Decision Guide and scored. The Department did not otherwise assert the guide had been incorrectly completed with respect to the score for interventions.

The Respite Decision guide scored 1 for care giver work/school schedule. This was not in dispute at hearing, nor were the sections for dependents and caregiver health. The Department did not dispute the total score derived is 14. The ALJ sought to learn what the usual recommendation would be for a score of 14 but could not get the answer through testimony or documentation.

This ALJ believes the Respite Decision Guide is good evidence of medical necessity for respite. This belief is based upon the evidence of specific family circumstances, needs and behaviors of the Appellant and amount and type of care being provided. All areas contained in the document appear to be relevant considerations concerning a need for a break from care giving. This ALJ understands the document is not a rigid chart that cannot be adjusted, however, that is not the finding of this ALJ. Again, the finding is that it is good evidence of medical necessity for respite services. While the result of scoring a 14 is not known to this ALJ, the recommendation of the supports coordinator is known. The supports coordinator completed the Respite Decision Guide according to the testimony of the Department witness. Her recommendation was for 12 hours per week and 24 overnights per year. This ALJ cannot be certain the supports coordinator's recommendation is the result yielded by completing the Respite Decision Guide that is (partially)

in evidence. When considering the interventions described by the Appellant's mother in both type and number, along with the particular family circumstance of 4 additional younger siblings, it is clear that medical necessity exists for regular respite for the Appellant's care givers. The Department does authorize an amount of respite time that averages 6 hours per week, in addition to 10 overnight stays for a 1 year period. This respite authorization represents a substantial reduction from that authorized when the Appellant was a minor whose services were funded differently. Uncontested testimony establishes he used to have authorization for over 1100 hours per year of respite. The Department was specifically asked why the authorization is so much lower now. The witness testimony is that he now has Home Help Services in place. The Appellant does receive 10 hours per week HHS. That is uncontested. This does not compel or persuade this ALJ that the 552 total respite hours authorized is sufficient to meet the medically necessary needs established through the Respite Decision Guide and relevant testimony taken at hearing.

This ALJ finds the relevant and material evidence of record is established by the Respite Decision Guide put into evidence. Coupled with the credible testimony from the Appellant's mother relative to the interventions, over-stimulation in his home environment and actual school schedule, this ALJ finds an increase in respite hours is medically necessary in this case. The number of hours in a 1 year period is 8760. Having a break in unpaid care giving sufficient to meet the stated goals of respite requires breaks sufficient in amount, scope and duration (length) to provide rest and relieve care giver stress. This ALJ believes an amount of respite equal to 10% of the total hours is medically necessary to achieve the stated goals of the service. This ALJ finds 876 hours of respite annually is likely sufficient in amount, scope and duration to meet medically necessary needs of the Appellant in this case.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Appellant shall be provided 876 hours of respite services annually.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: ___11/6/2009___

***** 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.