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. 2011-38912 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on Wednesday, [redacted], attorney, appeared on behalf of the Appellant. His witness was the Appellant's mother, [redacted], MLSW. [redacted], Hearings Coordinator, represented the Department. Her witness was [redacted], MLSW, Utilization Care Coordinator.

ISSUE

Did the [redacted] Community Mental Health SP properly assess the Appellant's request for additional Respite?

Did the Appellant knowingly close her case and extinguish her right to receive on-going respite while her appeal pends before the Michigan Administrative Hearing System?

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 disabled, [redacted]-year-old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with PTSD, RAD, and OCD. She is indentified as a child with SED. (Appellant's Exhibit #2, page 3)

3. In [redacted] the Appellant was identified as a child afflicted with a SPMI, SED, ADHD, PTSD, RAD, Depressive Disorder, and Conduct Disorder. (Appellant's Exhibit #2, page 13)

4. In [redacted] the Appellant was identified as a child afflicted with a SPMI, SED, ADHD, PTSD, RAD, Depressive Disorder and Conduct Disorder. (Appellant's Exhibit #2, page 21)

5. On [redacted], the Respite Assessment was sent to the Utilization Management Department for "scoring" where it was determined that the Appellant "scored 32 hours."

6. On [redacted], the parties were subject to an IPOS agreement indicating 60 hours of Respite per month. (Department's Exhibit A, page 12)

7. On [redacted], a denial notice was sent to the Appellant's parents. (Department's Exhibit A, pp. 13-15)

8. The Appellant's guardian testified that she unwittingly signed an EMR electronic receipt terminating her existing Respite agreement as instructed by her Case Manager, [redacted]. (Department's Exhibit A, page 11)

9. The Appellant testified that she did not see what she was signing by way of electronic device; she voiced that concern to Case Manager [redacted] and further stated that she wished for her case to remain open if an appeal were necessary. (*See* Testimony and Appellant's Exhibit #1, pages 1 and 2)

10. A timely appeal was received by the Michigan Administrative Hearing System for the Department of Community Health on [redacted]; this petition was incorporated with the Appellant's earlier petition dated received [redacted]. (Appellant's Exhibit #1).

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 she 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. Genesee County Community Mental Health SP 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. The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. In addition to establishing the framework for medical necessity[1] it states, in relevant part:

> **CRITERIA FOR AUTHORIZING**
>
> 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

[1] *See* MPM, Mental Health [ ] §§ 2.5 through 2.5D, Medical Necessity Criteria, pp. 12-14, July 1, 2011.

- 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) that 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. (Emphasis supplied)

MPM, Mental Health [ ] §17.2 Criteria for Authorizing B3 Supports and Services, p. 104, July 1, 2011.[2]

The MPM, Mental Health/Substance Abuse section establishes Medicaid policy for Michigan. With regard to Respite the manual states:

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[2] This version of the MPM is identical to the edition in place at the time of notice and appeal.

[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. (Emphasis supplied)

MPM Mental Health [ ] §17.3. J, Respite, pp. 117, 118, July 1, 2011

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At hearing the Department witness established that the Appellant's request for increased respite was denied and reduced because the blind assessment conducted by the Case Manager, as scored by the witness, resulted in fewer hours of medically necessary respite.

She explained that the scoring was similar to past years when the Appellant was deemed eligible for 60-hours of respite, but that now the [confidential] scoring tool was changed to reflect a zero-hour starting point – instead of the prior 20-hour starting point.

The Department witness also explained that the assessment and its scoring were conducted only with clinical documentation consisting of the Respite Assessment and IPOS. She said "no other records were available."

In her review of the scoring process the Department witness said she could not remember the hours/points levied under the Behavior/Emotional rubric – a section of clinical review containing nine (9) areas of assessment. The witness was neither able to recall verbally, nor in written form, how this scoring exercise reached 32 hours. [*See* Department's Exhibit A, page 5].

On cross examination the witness acknowledged that they did not share the scoring tool with the Appellant or disclose the new starting point and related deductions. [*See* Testimony of [redacted] and Appellant's Exhibit #2, at page 1].

The Appellant's mother testified that the Appellant's condition had worsened as exemplified by her new behaviors of stealing, increased violence directed at her younger siblings, defiance, refusal of hygiene and refusal of therapy. She added that since the last IPOS the Appellant's condition had significantly worsened. They utilized a behavior plan and added a crisis plan – which was still in use today. She said this information was shared with the Case Manager, [redacted].

The Appellant's mother also stated that she was told by the Case Manager, [redacted], that in order to request additional respite – it would be necessary to "close [her] current case and then open a new case" – the witness said this was explained while she was signing an unknown electronic receipt pad. The Appellant said she never saw the documents she was acknowledging – only the signature line.

On cross examination she said that the words "early termination" were never uttered, but that she did express concern to [redacted] about being required to sign-off on documents she was not allowed to review.[3]

The witness added that the need for respite had increased owing to the erosion of readily available natural supports. She said "not many" were left. She added that respite was used

[3] The result was that the Appellant's mother, a sophisticated consumer of CMH services, went forward on appeal with 32 hours instead of 60. On direct examination, the Appellant's mother, [redacted], MLSW, was identified as a former CMH employee and current [redacted] Court liaison to the [redacted] CMH for therapeutic care to foster children. Based on this record the ALJ finds it highly unlikely that "early termination" was a knowing and informed action on the part of this consumer.

for a break, appointments for the other children, grocery shopping, household chores and to allow her to receive necessary infusion therapy.

On review, the Department failed to document or explain how the Behavior/Emotion rubric of the assessment tool was scored. When coupled with the administrative changes in the scoring process [changing the baseline to zero without notice] it is clear that the number of respite hours was reached on non-medical criteria. The resulting reduction in respite was not supported with these facts.

The Appellant preponderated her burden of proof that the Department erred in calculating the number of respite hours which could be supported by evidence. Furthermore, I find that the Department improperly caused the early termination of the Appellant's preexisting respite case. This resulted in the denial of services based on cost while impermissibly defeating the Appellant's rights on timely appeal. [MPM, 2.5.D *supra*]

Today, the Department's Respite calculation [at 32 hours] is not supported by medical necessity or the documentation submitted for review today. The Department's methodology in reducing the number of respite hours rested on scoring benchmarks - not medical necessity.

This Administrative Law Judge must follow the CFR and the state Medicaid policy. The Appellant preponderated her burden of proof to establish that the Department erred in assessing the number of her medically necessary Respite hours.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly reduced respite to the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

IT IS FURTHER ORDERED that:

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The Dep/artment shall REINSTATE the Appellant's Respite grant to that in effect on [redacted], and shall REASSESS the Appellant's request for increased RESPITE in a face to face meeting within 30-days receipt of this Decision and Order or as soon as might reasonably be scheduled between the parties, thereafter.

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Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
Docket No. 2011-38912 CMH
Decision and Order

cc: [redacted]

Date Mailed: 9/23/2011

/* 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.