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. 2012-1753 CMH
Case No. 38024096

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]. Attorney [redacted] represented Appellant. [redacted], Appellant's mother, also testified on behalf of Appellant. [redacted], Manager of Due Process, appeared on behalf of the [redacted] County Community Mental Health (CMH). [redacted], Manager of Utilization Management, appeared as a witness for the CMH. Following the hearing, the record was left open so that Appellant could submit additional evidence and argument. The CMH was also given an opportunity to respond and submit additional evidence.[1]

ISSUE

Did the CMH properly deny Appellant's request for 96 hours of respite care services per month and instead authorize 48 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 who has been diagnosed with autism, fetal alcohol syndrome, major emotional disturbances of childhood, and a

[1] Appellant's hearing was also consolidated with the hearing for her sister [redacted] (Docket No. 2012-1752; Case No. 38023812). The exhibits admitted include the CMH's pre-hearing evidence with respect to [redacted] (Exhibit 1, pages 1-55); Appellant's pre-hearing evidence with respect to [redacted] (Exhibit 2, pages A-UU); Appellant's post-hearing evidence with respect to [redacted] (Exhibit 3, pages 1-15); the CMH's post-hearing evidence with respect to [redacted] (Exhibit 4, pages 1-90); the CMH's pre-hearing evidence with respect to [redacted] (Exhibit 5, pages 1-55); Appellant's pre-hearing evidence with respect to [redacted] (Exhibit 6, pages A-UU); Appellant's post-hearing evidence with respect to [redacted] (Exhibit 7, pages 1-15); and the CMH's post-hearing evidence with respect to [redacted] (Exhibit 8, pages 1-91).

history of reactive attachment disorder. (Exhibit 1, pages 1, 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 78 hours of respite care services per month through the CMH. Appellant's mother also receives an adoption subsidy through the State of Michigan. (Exhibit 1, page 2).

4. On [redacted], the CMH conducted a Respite Assessment. (Exhibit 1, pages 1-5). Appellant's mother requested 96 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 48 hours of respite care per month. (Testimony of [redacted]).

6. On [redacted], the CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the request for 96 hours per month of respite was denied, but that 48 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].

8. During the hearing on [redacted], the CMH's representative and witness both stated that, based on the testimony presented, the CMH would increase Appellant's respite care by another 2 hours per month. (Testimony of [redacted]; 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 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.
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> (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**
>
> 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)*

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.
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> *(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 96 hours of respite care services per month and only authorize of 48 hours of respite care services per month must be sustained as it is reflective of the need for assistance and provides Appellant's mother with significant, temporary relief.

CMH witness [redacted], Manager of Utilization Management Coordinator, 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 [redacted] County. According to [redacted], staff from Child and Family Services meets with the parent(s) and fills out the respite assessment form. The form in this case was completed by [redacted]. In conducting the respite assessment, the clinicians who 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. According to [redacted], 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] testified that, in his professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services.

[redacted] reviewed Appellant's Respite Assessment during the hearing, but he also acknowledged that he neither filled out the respite assessment form nor scored the form initially. He also testified that he has never met Appellant.

[redacted] testified that, according to the scoring tool, Appellant was awarded 2 respite hours because Appellant's has two or more caregivers; one who works or is in school full-time or part-time[2], 2 respite hours because Appellant's father's depression and Appellant's mother's high blood pressure and high cholesterol interfere with the provision of care, and 4 respite hours because there was an average of three or more interventions per night.

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

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[2] [redacted] also testified that the scoring for the availability of caregivers living in the home was based on the clinical notes, which identified two caregivers, rather than the checked box, which only identified one caregiver. (Testimony of [redacted]; Exhibit 1, page 3).

[3] [redacted] testified that, because she is a child, Appellant should have only been scored 1 respite hour because of her daily temper tantrums, but that the scorer erred in Appellant's favor and the CMH let the error stand. (Testimony of [redacted]; Exhibit 1, page 4).

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

As stated in [redacted] testimony, Appellant was also awarded 4 respite hours per month because she requires total assistance with grooming and 3 respite hours because she 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 hours were awarded in this case. With respect to Appellant's narrative [redacted] also specifically testified that the presence of other siblings who require assistance does not affect Appellant's respite hours as each sibling is assessed individually.

[redacted] further testified that he referred to the Medicaid Provider Manual policy section for determination of medical necessity. He 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; it is not intended to be provided on a continuous or daily basis.

Appellant's mother testified that Appellant's respite hours have changed greatly over the last few years. According to [redacted], Appellant received 34 respite hours per month two years ago and 78 respite hours per month last year, before being allocated 48 respite hours per month this year. She also testified that the changes in respite hours were made without Appellant undergoing any significant medical or behavioral changes.

With respect to the scoring tool used during the most recent assessment Appellant's mother testified that she disagreed with the 2 respite hours awarded for assistance with self care-eating. According to [redacted], while it states on the respite assessment form that Appellant eats independent after set up, Appellant actually requires more assistance with eating, including assistance in monitoring the amount she eats and cutting her food.

In response to Appellant's mother's testimony regarding self care-eating, [redacted] testified that Appellant would be granted an additional 2 hours of respite per month as it

[4] [redacted] testified that Appellant should have only been scored 3 respite hours for the assistance she requires with self-care dressing, but that the scorer erred in Appellant's favor and the CMH let the error stand. (Testimony of [redacted]; Exhibit 1, page 4).

appears Appellant requires total physical assistance with that task. However, that new authorization does not affect that CMH's previous decision as [redacted] characterized [redacted] testimony as new and she does not recall what she said during the assessment. Accordingly, there is no basis for finding that the CMH erred in awarded respite hours with respect to the self care-eating factor.

Appellant's mother further testified that, while the respite assessment form does not include a checkmark for "Non-verbal communication" (Exhibit 1, page 5), Appellant is often mute and difficult to communicate with. However, [redacted] testified in response that, with respect to non-verbal communication, no respite hours are awarded for non-physical difficulties in communicating, such as the difficulties Appellant has.

The scoring for mobility was also discussed during the hearing as Appellant's attorney noted that Appellant requires frequent monitoring. However, [redacted] testified that this factor refers to a need for assistance with mobility due to physical factors and that the type of assistance identified by Appellant is encompassed by wandering category, for which Appellant was awarded respite hours.

During the hearing, whether or not Appellant has a behavioral plan in place was discussed. According to [redacted], if such a plan was in place, Appellant would be granted 10 additional respite hours per month. However, such a plan would have to have been written by a mental health professional within the last year. Appellant's mother testified that Appellant did have a behavior plan in place once, but it was years ago and she told the person completing the most recent assessment that no plan was in place. No behavior plan was submitted as evidence by Appellant. Accordingly, the CMH's decision with respect to the absence of a behavior plan must ne affirmed.

In addition to the dispute over specific answers given during the respite assessment, Appellant also objects to the CMH's use of the scoring tool generally and the specific application of the scoring tool in this case. For example, Appellant first argues that the scoring tool used by the CMH is improper because it will always allocate less respite hours than the previous respite assessment process. As a preliminary matter, this Administrative Law Judge would note that Appellant's argument appears to be incorrect. Appellant argues that the maximum number of hours that can be awarded under the new scoring tool has been reduced to 80 hours, but that argument is contradicted both by [redacted]s specific testimony and the scoring tool itself. While, according to the CMH, Appellant will not receive the maximum number of respite hours allowable (96), another person could in the appropriate circumstances. Regarding specific factors in the respite assessments, Appellant also appears to err in factoring in the need for a behavioral plan to justify hours under the old respite process and the presence of discretionary hours within the new scoring tool.

Moreover, even if it is true that the new scoring tool will inevitably allocate less respite hours than the previous assessment process, that does not mean that use of the scoring tool is improper. [redacted] testified that the CMH developed the new scoring tool in part because the old respite assessment process was awarding 20 hours of respite

care automatically and was an outlier with respect to the hours awarded by other agencies, which suggests that the previous assessment process was awarding too many respite hours and was not based on medical necessity. In any event, the ultimate question remains whether the denied hours were medically necessary and, even assuming for the sake of argument that the scoring tool will inevitably award less respite hours than the previous tool, the burden still remains on Appellant to demonstrate by a preponderance of the evidence that, in this case, the CMH erred in allocating the amount of respite hours.

With respect to the scoring tool used by the CMH, both Appellant and the CMH submitted other decisions discussing the same respite assessment process used in this case. (Exhibit 3, pages 8-15; Exhibit 4, pages 13-90). Given the fact that those opinions are not dispositive here, as well as the conflict between the submitted opinions, it is not clear that they have much relevance. However, all but one of the cases provided do affirm the use of the scoring tool by the CMH. Moreover, in the [redacted] case relied upon by Appellant, the CMH's witness was unable to testify in detail regarding how the scoring tool was utilized and scored (Exhibit 3, pages 13-14), which is not the situation in this case. Therefore, to the extent the other cases are even relevant, this Administrative Law Judge finds that they support the CMH's decision.

Appellant also argues that the use of the respite assessment scoring tool violates the MPM because it does not satisfy the "person-centered planning" requirement of the MPM. As provided in the MPM, "[d]ecisions about the methods and amounts of respite should be decided during person-centered planning." *(MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 118)*. However, while the MPM is replete with references to person-centered planning, that concept is not expressly described and Appellant does not elaborate on why the requirement is not met in this case. At one point, the MPM does provide

> Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.
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> *(MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 4)*

Similarly, those guidelines also focus on letting the individual directing the planning process, with a focus on what he/she wants and needs, and awarding services on an individualized basis. While those choices and preferences are not always granted, they

are considered and respected. (Person-Centered Planning Revised Practice Guideline, October 2002). Here, while the CMH used the same scoring tool it uses with every client, it also applied that tool to her individual circumstances while also considering her request for respite services. [redacted] expressly testified that, in addition to the scored questions, the Appellant's narrative was also considered and nothing in that section justified additional respite hours. Appellant also fails to identify any specific individual aspects of her situation that were not considered and would justify additional hours. Accordingly, Appellant's argument that the use of the scoring tools means that services are not decided during the person-centered planning must be rejected.

Appellant further argues that the CMH violated the MPM by improperly denying or basing services on preset limits. The MPM does provide that a "PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services." (*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 14*). Appellant argues that the "assessment tool used by the department is exactly the kind of preset limit barred by the Manual." (Exhibit 3, pages 4-5). However, Appellant provides no support for that assertion and it appears false given the evidence. [redacted] specifically testified that, depending on the facts in an individual case, a client could score anywhere from 0 to 96 hours of respite care. (Testimony of [redacted]). An examination of the scoring tool also reveals that 96 hours is obtainable. (Exhibit 2, pages B-C). "The maximum monthly respite allocation is 96 hours" (*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 74*), but that limit is set by the MPM. To the extent Appellant is arguing that there should be no limit on the hours that can be allocated for any one factor, her argument must still be rejected. The scoring tool does appear to limit, for example, the respite hours allocated for daily verbal abuse by a child to 2 hours per month. (Exhibit 2, page B). However, such an argument ignores the discretionary hours that can be awarded by the scorer. (Testimony of [redacted]).

Additionally, Appellant argues that the use of the CMH's scoring tool is improper because it does not determine the need for services on an individual basis. As described above, a PIHP 's "determination of the need for services shall be conducted on an individualized basis." (*MPM, Mental Health and Substance Abuse Section, October 1, 2011, page 14*). According to Appellant, the individual aspect of her situation, as recounted in the narrative section of the respite assessment form, were not scored. However, [redacted] expressly testified that the Appellant's narrative was considered, but that nothing in it justified additional respite hours. Therefore, contrary to Appellant's argument, the narrative section of the respite assessment was scored and that score was a zero. Appellant also fails to identify any specific individual aspects of her situation that would justify additional hours and, consequently, the argument that her services were not determined on an individualized basis is rejected.

Finally, Appellant argues that the use of the scoring tool violates the MPM because it requires active treatment as a prerequisite for receiving respite care. As stated above, the MPM does provide that "PIHPs may not require active clinical treatment as a prerequisite for receiving respite care." (*MPM, Mental Health and Substance Abuse*

Section, October 1, 2011, page 118). According to Appellant, the scoring tool is therefore improper as it awards 10 respite hours if there is a behavior plan in place. However, while the presence of a behavior plan affects the number of hours allocated, it is clearly not a prerequisite for receiving respite care because, as in this case, a client can receive respite care without having a behavior plan in place.

Regarding the application of the scoring tool and respite assessment in her specific case, Appellant's attorney argues that the CMH erred because, while Appellant's condition and behavior have been getting worse, the number of respite hours has been reduced. However, each respite assessment is completely independently and, while previous allocation of hours may be relevant, they are not controlling. Moreover, as discussed above, [redacted] testified as to why the new scoring tool was adopted and why it is more accurate. [redacted] also testified that, given the updates/corrections to the scoring tool, there could be a situation where respite hours are reduced despite a worsening condition. Similarly, while Appellant argues that the old respite assessment process was better because it was longer and requested more detailed information, she fails to identify any information that was not considered by the CMH here. Appellant also fails to argue why the information considered by the CMH justifies additional respite hours. Additionally, Appellant's mother specifically testified that the changes in Appellant's respite hours over the last few years have occurred without any significant changes in her conditions or behavior.

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 the Appellant's mother. Appellant's attorney 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 CMH properly authorized 48 hours of respite care per month rather than the 96 hours requested by 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: 12/22/2011

***** 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.