

**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:

██████████,

Appellant

Docket No. 2012-5577 CMH  
Case No. 1035283832

**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 ██████████. <sup>1</sup> Attorney ██████████ appeared on behalf of Appellant. ██████████, ██████████, and ██████████ testified as witnesses for Appellant. ██████████, Manager of Due Process, appeared on behalf of the ██████████ County Community Mental Health (CMH). ██████████, ██████████, and ██████████ appeared as witnesses for the CMH.

**ISSUE**

Did the CMH properly deny Appellant's request for 80 hours of respite care services per month and instead authorize 62 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 ██████ year-old boy who has been diagnosed as a child with a Serious Emotional Disturbance and specifically diagnosed with Disruptive Behavior Disorder NOS and hyperactivity disorder. (Exhibit 6, page L). Appellant also suffers from Grand mal seizures. (Testimony of ██████████).
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.

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<sup>1</sup> Appellant's hearing was consolidated with the hearings for his sisters ██████████ (Docket No. 2012-9365) and ██████████ (Docket No. 2012-5578).

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3. Appellant had been receiving 80 hours of respite care services per month through the CMH. (Testimony of ██████████).
4. On ██████████, the CMH conducted another Respite Assessment. (Exhibit 5, pages 1-5). Appellant's parents again requested 80 hours of respite care per month. (Exhibit 5, page 2).
5. Based on the assessment and the scoring tool used by the CMH, the CMH only authorized 62 hours of respite care per month. (Testimony of ██████████).
6. On ██████████, the CMH sent notice to Appellant notifying him that the request for 80 hours per month of respite was denied, but that 62 hours of respite per month were approved effective ██████████. (Exhibit 1, pages 6-8).
7. The Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing on ██████████.

**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**

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**

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

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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 80 hours of respite care services per month and only authorize of 62 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 ██████████, Utilization Management Care Coordinator, testified in this case regarding the process for assessment and allocation of respite hours used by the CMH. According to ██████████, the MDCH does not provide a screening tool for respite care and the CMH has therefore developed its own tool that is only used in ██████████ County. ██████████ was part of the team that developed the scoring tool.

██████████ testified that, as part of the assessment and allocation process, staff from Child and Family Services meets with the client and others in order to fill out the respite assessment form. However, in conducting the respite assessment, the staff members 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. Subsequently, the Utilization Management section of the CMH receives a request for authorization, along with the respite assessment form, and Utilization

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Management Coordinators apply a scoring tool and assign respite hours based on the respite assessment form. The scorer does not have any face-to-face contact with the client. When scoring the form, the scorer can also look at the amount of respite hours previously authorized if appropriate. An example of such a situation given by ██████████ was when there is a significant change in the number of hours requested.

██████████ also 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. However, it is still possible to get the maximum 96 hours of respite care services through the new scoring tool and ██████████ testified that, in her professional opinion, the scoring tool now being used by the CMH accurately reflects the client's needs for respite services. ██████████ also asserted 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.

██████████ further testified regarding other specific changes made from the earlier scoring tool to the one used in the assessment at issue here. For example, the starting point of 20 hours of respite care per month under the prior scoring tool has been eliminated in order to accurately reflect need. Another change was to clarify the behavioral section in order to remove the subjectivity from the scoring and achieve more accurate and uniform scoring within their department.

With respect to the availability of caregivers, definitions and language were added. However, the maximum number of hours (6) that could be awarded for this factor remained the same. The hours that could be allocated due to the condition of caretaker also remained the same.

Regarding nighttime interventions, a client can now only be awarded a maximum of 4 respite hours a month, whereas he could receive 6 hours under the previous tool. According to ██████████, the change was due to a change in policy in the Children's Waiver Program.

██████████ testified that, with respect to the behavioral/emotional section of the scoring tool, a client could receive up to 30 hours under either scoring tool. However, given issues with the different credentials of staff members and subjective judgments, the new scoring tool clarified the most common behaviors into 9 categories. Moreover, according to ██████████, a behavior plan was necessary to receive the full 30 hours under either scoring tool.

██████████ further testified that, while the number of respite hours that could be assigned for factors such as mobility, oral care, eating, bathing, toileting and dressing remained the same, more choices were added to allow for greater clarification. Also, the CMH added a new category for dietary needs and replaced hair care with grooming, which also encompasses more tasks.

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As stated by ██████████, the new scoring tool also distinguishes between the need for medication administration by age because it is still a parent's duty to administer medication to children. Only a need for medication administration with clients over the age of 18 justifies respite hours. ██████████ also stated that a client can receive 2 respite hours a month due to non-verbal communication and 3 hours a month if the client requires extensive prompting and encouragement to participate in things.

██████████ further 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.

With respect to Appellant's score in this case, Care Coordinator ██████████ testified that she calculated Appellant's respite hours from the respite assessment form. According to ██████████, based on the narrative stating that both of Appellant's caregivers work or are in school full-time or part-time, Appellant was awarded 4 respite hours per month. ██████████ also testified that Appellant was awarded 2 hours because his mother's medical conditions interfere with his care and 4 respite hours because there is an average of 3 or more interventions per night.

██████████ further testified that 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 is physically abusive to himself weekly, 1 respite hour because he engages in inappropriate touching weekly, 1 respite hour because he strips in public weekly, 3 respite hours because he engages in the destruction or disruption of property daily, 1 respite hour because he has daily temper tantrums, and 2 respite hours because he wanders daily. Appellant was also awarded 10 respite hours because a behavior plan is in place for him.

██████████ also testified that Appellant was awarded 2 respite hours per month because he requires shadowing or has an unsteady gait with respect to mobility, 4 respite hours because Appellant requires total physical assistance with self care-oral care, 3 respite hours because he only eats independent after set up<sup>2</sup>, 4 respite hours because Appellant requires total physical assistance with self care-bathing, 4 respite hours because Appellant requires total physical assistance with self care-toileting, and 3 respite hours because Appellant requires assistance with self care-dressing.

As stated in ██████████' 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.

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<sup>2</sup> According to ██████████, Appellant should have only been awarded 2 respite hours for his needs with respect to self care-eating, but she erred in his favor by scoring 3 hours and the CMH let the error stand.

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Overall, Appellant was therefore awarded 62 hours of respite care per month instead of the 80 hours he requested. For the reasons discussed below, this Administrative Law Judge finds that the CMH's decision should be sustained.

In response to the above testimony and evidence, Appellant's attorney raised arguments generally challenging the use of the scoring tool by the CMH. For example, Appellant's attorney 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.

(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 Appellant's individual circumstances while also considering his request for respite services. Additionally, ██████████ expressly testified and explained why it would not be feasible to determine respite hours at the exact time the person-centered plan is developed. Accordingly, Appellant's argument that the use of the scoring tool means that services are not decided during the person-centered planning must be rejected.

Appellant also appears to argue 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). However, the CMH did not deny any services because of preset limits. ██████████

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specifically testified that, depending on the facts in an individual case, a client could score anywhere from 0 to 96 hours of respite care hours per month and an examination of the scoring tool also reveals that 96 hours is obtainable. “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.

Appellant further argues that the use of the scoring tool is improper because the person filling out form does not know what is important while the person scoring the form never meets with the client face-to-face. However, no such requirement is found in the Medicaid Provider Manual. Moreover, ██████████ testified that, given the number of clients involved, face-to-face meetings between the clients and scorers are not possible. ██████████ also testified that the CMH trains the staff filling out the respite assessment forms on how to complete those forms. Similarly, Clinical Therapist ██████████ testified that, when she was completing the respite assessment forms for Appellant and his sister, she tried to be as complete as possible. To the extent Appellant argues that the respite assessment form in this case was incomplete, that argument will be addressed below. Appellant’s general argument that the use of the scoring tool is improper must be rejected.

In addition to the general objections to the scoring tool used by the CMH, Appellant also challenges the specific application of the scoring tool to his case. For example, Appellant’s mother testified that Appellant’s respite hours have been reduced from previous years despite the fact that his behavior is actually worsening. Specifically, ██████████ testified that Appellant has difficulty communicating and sleeping. Appellant is also obsessive and has no sense of safety. Appellant’s mother also described occasions where Appellant got stuck in a tall tree he climbed or left the family home in the middle of the night to break into a van and a neighbor’s house. Appellant’s home is now equipped with alarms and locks to prevent Appellant from leaving.

However, the mere fact that an Appellant may receive less respite hours despite worsening behavior is not dispositive in this case. ██████████ 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. The ultimate question remains whether the denied hours were medically necessary and 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.

Appellant first attempts to meet that burden by arguing that the CMH should have awarded some of the possible discretionary hours. As described above, while the scoring tool allows for 13 hours of respite care hours to be awarded for discretionary reasons, no such hours were awarded in this case.

Appellant’s attorney argues that the presence of multiple kids with special needs in home justifies an award of additional respite hours. It is undisputed that two of

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Appellant's siblings have special needs and exhibit behavioral issues. Moreover, as described by ██████████, the siblings feed off each other's behavior in a vicious cycle. Psychologist ██████████ also testified that, given the interactions among the children, the whole problem they present is greater than the sum of their individual problems. However, the respite assessment form specifically addresses and accounts for some of the interaction between Appellant and his siblings. For example, as described above, the CMH awarded respite hours because Appellant is verbally and physically abusive to others daily and because he engages in inappropriate touching weekly. Moreover, other activities that may stem from Appellant's relationship with his siblings, such as temper tantrums, destruction of property or self physical abuse, were also accounted for and lead to respite hours. Appellant's mother fails to describe any behavior between the siblings that was not accounted for and, consequently, the CMH properly found that the presence of multiple kids with special needs in home did not justify an award of additional respite hours.

Appellant's attorney also argues that the CMH erred by not taking into account the need to use a special harness and child locks when driving Appellant anywhere. However, such a need is documented in a narrative section of Appellant's respite assessment form. (Exhibit 5, page 3). The CMH therefore did not ignore the need for a harness and locks; it instead rejected that need as a basis for more respite hours. As testified to by ██████████, the rejection is based on the fact that the reasons Appellant need a special harness and child locks are already accounted for in the behavioral and emotional section of the respite assessment form.

Appellant's mother further challenges some of the specific, identified factors of the scoring tool. For example, she testified that, while the respite assessment form provides that Appellant eats independent after set up, he actually requires assistance/prompting or reminders at the very least. Appellant's mother also testified that Appellant has to use specialized equipment when eating because of the tremors he suffers, and that she has to cut up his food and feed him at times. If the CMH had marked Appellant as requiring assistance/prompting or reminders with respect to self care-eating as Appellant's mother wished, then he would have received 3 respite hours per month rather than 2 awarded for eats independent after set up. However, as noted above, ██████████ testified that she erred when scoring the form and she awarded him 3 respite hours per month with respect to self care-eating rather than the 2 hours he should have received and the CMH let the error stand. Accordingly, Appellant is already receiving the 3 respite hours per month due to his eating needs that he would receive if the form had been marked as Appellant's mother wished.

Appellant's mother further testified that Appellant should have been awarded some respite hours because of his dietary needs. As stated in both ██████████ testimony and a narrative section of Appellant's respite assessment form, Appellant requires a high calorie diet. As testified to by ██████████, the CMH added a new category for dietary needs in its most recent assessment form and a client can receive 3 respite hours a month due to that factor. Nevertheless, the mere fact that Appellant requires a high calorie diet is not enough and ██████████ testified that the CMH is instead looking for needs

such as a need for food texture modification or a gluten-free diet because those needs require the parents to take time to meet it, whether in shopping or in preparing food.

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 the calculation of Appellant's respite hours and why those respite hours 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 and that the CMH failed to take into account all of his needs, but this Administrative Law Judge finds those arguments to be unpersuasive for the reasons stated above. The CMH took into account all of the relevant factors and properly assessed Appellant for respite care hours.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly authorized 62 hours of respite care per month based on the information available at the time of its decision.

**IT IS THEREFORE ORDERED** that:

The CMH's decision is AFFIRMED.

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

cc:



Date Mailed: 1/12/2012

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**\*\*\* 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.