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. 2009-11445 CMH
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], Appellant's mother/legal guardian, appeared and testified on behalf of Appellant. [redacted] appeared as a witness for Appellant. [redacted], represented the Department's agent, [redacted]. [redacted]irector, appeared and testified as a witness for the Department.

ISSUE

Did the Department [redacted] properly determine Appellant's eligibility for Respite services?

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 Medicaid beneficiary who is receiving services through [redacted].

2. [redacted] is a Prepaid Inpatient Health Plan (PIHP) under contract with the Michigan Department of Community Health (Department) to provide Medicaid covered services to Medicaid beneficiaries who reside in [redacted].

3. Appellant resides with her mother/legal guardian/primary caretaker.

4. Appellant, is a [redacted]-year-old female who was diagnosed with Severe Mental Retardation and Convulsive Epilepsy. (Exhibit 1, p. 3)

5. Appellant had been receiving non-Medicaid-funded Respite through [redacted]. (Exhibit 1, p. 10)

6. The [redacted] that Appellant was receiving was funded with general funds and ended on [redacted]. (Exhibit 1, p. 10)

7. After Appellant stopped receiving [redacted], [redacted] did an assessment to determine Appellant's eligibility for In-Home Medicaid-funded Respite.

8. At the time of the assessment for Respite, Appellant's caregiver/mother was not working.

9. [redacted] completed an Adult Respite Profile of Appellant to determine her level of need for Respite based on its Adult Respite Scoring Scale which considers the work status and health status of the caregiver, and the behavioral and health/medical needs of the client. (ALJ I)

10. Appellant scored a 14 on the Adult Respite Scoring Scale, which indicates a high need for Respite. (ALJ I)

11. [redacted] determined that Appellant was eligible for 325 hours, 27 hours per month, of In-Home Respite for the period of [redacted] through [redacted], and sent Appellant's legal guardian notice of the eligibility determination.

12. On [redacted], the State Office of Administrative Hearings and Rules received a hearing request, filed by Appellant's legal guardian, protesting the number of Medicaid-funded Respite hours Appellant was determined eligible to receive through [redacted] for the year [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*

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…

Section 1915 (c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the

> provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide Medicaid funded services through the CMH Managed Care Provider Network to persons who meet the service selection criteria for Medicaid funded services.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. 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.* CMH is required to use a person-centered planning process to identify medically necessary services and how those needs would be met. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

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.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may deny services that are:

- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual, Mental Health/Substance Abuse section, Version Date: October 1, 2007

The definition of Respite care services can be found in the Medicaid Provider Manual, Mental Health/Substance Abuse, effective January 1, 2008:

> 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 care giver. 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
> - 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.

Appellant's mother is protesting the amount of Respite hours that Appellant was determined eligible to receive for the year [redacted]. Appellant had been receiving non-Medicaid-funded Respite hours through [redacted]. These non-Medicaid-funded services terminated and were replaced by Medicaid-funded Respite services; however, the approved hours were less. Appellant's mother feels that Appellant should receive the same number of Respite hours that she had been receiving through [redacted].

Appellant's mother/representative had the burden of proving by a preponderance of evidence that the Medicaid-funded Respite service hours that she is requesting on Appellant's behalf is medically necessary and appropriate in amount, scope and duration. In other words, Respite must be medically necessary and appropriate in amount to achieve its purpose. (See the aforementioned policy on Respite care service) Additionally, Respite is a service that accommodates the various home settings, primary caregiver need, and Medicaid beneficiary need. The [redacted] witness provided evidence to establish that based on Appellant's Adult Respite Profile score, she has a high need for Respite. The Department uses an Adult Respite Profile tool to determine the client's level of need for Respite. The level of need for Respite can result in the following: Not eligible, Low Need, Medium Need, High Need, and Very High Need. [redacted] established that it took into consideration the work status and health status of the caregiver, the behavioral and health/medical needs of Appellant, and Appellant's Personal Care Plan in determining Appellant's level of need for Respite services. Appellant was determined eligible for 325 hours, 27 hours per month, of In-Home Respite for the period of [redacted] through [redacted], [redacted].

Appellant's mother failed to establish that the additional Respite hours that she is requesting on Appellant's behalf is medically necessary and appropriate for her family, and she failed to establish that the 325 Respite hours for the year [redacted] are not appropriate in amount, scope, and duration. Further, she failed to establish that there is a likelihood of adverse outcomes that will affect her family unit if the additional Respite hours or services that she is requesting are not authorized.

In conclusion, [redacted] established that it determined Appellant's eligibility for Respite services in accordance with the applicable Medical Necessity criteria found in the Medicaid Provider Manual, section 2.5.B. Therefore the Respite eligibility determination must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department/[redacted] properly determined Appellant's eligibility for Respite services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/18/2009

***** 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.