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. 2010-2705 CMH
[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] appeared on behalf of the Appellant. She had no witnesses. [redacted], hearings officer, represented the Department. His witnesses were [redacted], case manager. Also in attendance were employee observers [redacted]

ISSUE

Did the Department properly terminate the Appellant's 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. The Appellant is an [redacted]d Medicaid beneficiary. (Appellant's Exhibit 1)

2. The Appellant is enrolled in the [redacted]. (Appellant's Exhibit 1)

3. Community Mental Health for Central Michigan (CMHCM) is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

4. Appellant lives in [redacted], Michigan, with the "father of a friend" known to his natural supports. [Department's Exhibit A, (Sub G)]

5. The Appellant receives specialty mental health services in the form of medication monitoring, case manager monitoring and respite. [Department's Exhibit A, (Sub E and Sub F)]

6. The Appellant is afflicted with ADHD for which he takes relevant medication as monitored by a psychiatrist. [Department's Exhibit A (Sub J)]

7. The Department established that the Appellant was no longer eligible for respite services as he was an adult and had achieved the majority of his goals through his Person Centered Plan (PCP). [Department's Exhibit A (Sub M)]

8. He was not a person with a serious mental illness, developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder. [Department's Exhibit A (Sub H)]

9. The Department witness established that respite services were no longer medically necessary owing to the Appellant's progress and lack of impairment. [Department's Exhibit A (Sub M)]

10. The testimony of the parties established that the Appellant has no need for a primary care giver. He no longer lives at home and is an adult functioning in school and the community without constant supervision. [See testimony and Department's Exhibit A (Sub M)]

11. The Appellant was advised of the respite services termination by adequate action notice on [redacted] The Appellant's further appeal rights were explained therein. [Department's Exhibit A (Sub H)]

12. The instant appeal was received by SOAHR on [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

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 in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The Community Mental

Health for Central Michigan Community (the Department) contracts with the Michigan Department of Community Health to provide those services.

* * *

At issue today is whether the Department satisfied the requirements of medical necessity in evaluating the amount or termination of Appellant's respite services in conjunction with the Appellant's Personal Care Plan (PCP). The Department's position was that the Appellant had demonstrated through his PCP that he was an adult who was functioning in school and the community without constant supervision.

The Appellant also acknowledged in his PCP that respite services would end because of his lack of continued eligibility. He voiced no objection on the discontinuation of respite to his case manager, Sue Smith.

The Department's evidence adequately demonstrated that the Appellant no longer lives at home and functions in the community without supervision.

The Appellant's mother indicated that when the Appellant returns home he requires life organizing, transportation and separation from his siblings. She said she make sure he takes his medication.

The Department witness, [redacted], explained that the Appellant did not need a care giver – since the Appellant doesn't live at home and has largely met the goals in his PCP.

In determining its termination of respite services, CMHCM must apply the Department's medical necessity criteria. The Department's policy for medical necessity is as follows:

> **[ ] MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **[ ] 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.

[ ] 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.

Medicaid Provider Manual (MPM), Mental Health/Substance Abuse, Section 2.5, pp. 12-13, January 1, 2010

[ ] ADDITIONAL MENTAL HEALTH SERVICES

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically

necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

[ ] DEFINITIONS OF GOALS…

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation

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

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Independence

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

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

achieve the skills they need to be successful in school, enter adulthood and live independently. (Emphasis supplied)

MPM, Mental Health [ ], §§ 17 and 17.1, p. 97, January 1, 2010

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The Department demonstrated that the Appellant's diagnosis, as of [redacted] was ADHD, Conduct disorder by history, Depression NOS, resolved and Math learning disability [addressed]. *See* Department's Exhibit A (Sub J)

The evidence shows that [redacted] properly utilized its assessment tools to determine that the Appellant was no longer eligible for respite. Since it is apparent that the Appellant met the goals found in his Person Centered Planning the Department properly terminated respite services for lack of medical necessity.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides tha[redacted] properly terminated the Appellant's respite services.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/22/2010

***** 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.