

**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) 373-4147

IN THE MATTER OF:

**Docket No. 2013-44583 CMH**

██████████  
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 ██████████ ██████████ Appellant's stepfather appeared on the Appellant's behalf. ██████████ Appellant's sister gave testimony on behalf of the Appellant. Appellant's Mother ██████████ and the Appellant were also present for the hearing but did not testify.

Attorney ██████████, Corporation Counsel for ██████████ County Community Mental Health and Substance Abuse Services, the ██████████ that ██████████ County Community Mental Health and Substance Abuse Services is a part of, hereinafter CMH, represented the CMH. ██████████, MA, LLP, Utilization Review Coordinator for the ██████████, was present and gave testimony on behalf of the CMH.

**ISSUE**

Did the CMH properly reduce Appellant's respite care from ██████████ hours per month down to ██████████ hours 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. The Appellant is a ██████████ year old Medicaid beneficiary (██████████) who has been receiving mental health services as a child with developmental disabilities. (Testimony).

2. ██████████ County Community Mental Health and Substance Abuse Services is the Community Mental Health contractor with the State of ██████████. (hereinafter CMH)
3. The Appellant is a participant with CMH and has been receiving Medicaid covered services including case management services, psychiatric services, community living supports (CLS), and respite care. (Exhibit B, p. 5 and testimony).
4. The Appellant has been diagnosed with moderate mental retardation, ADHD, mood disorder, NOS, seizure disorder, enuresis, diabetes, and ventricular tachycardia. (Exhibit B, p. 7).
5. On ██████████, CMH determined that Appellant's CLS and respite should be reduced based on medical necessity criteria, and the reduction was included in Appellant's annual plan of care. (Exhibit A, pp. 1).
6. On ██████████, Appellant's request for hearing was received by MAHS. The request for hearing appealed the reduction of the number of hours authorized for Appellant's respite care. (Exhibit A, pp. 3-4).
7. Appellant also filed a local appeal of the decision to reduce his respite services, and after a review CMH determined that the decision to reduce respite services should be upheld. (Exhibit A, p. 1).
8. On ██████████, ██████████ MA, LLP, Utilization Review Coordinator for the ██████████ conducted a Utilization Management Review. ██████████ supported the reduction of Appellant's respite services. (Exhibit B).

### **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 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...

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 waiver. CMH contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

██████████ stated she was a Utilization Review Coordinator for the ██████████ and is a Limited License Psychologist. ██████████ stated she did a Utilization Management Review of the Appellant's electronic medical records from the ██████████ CMH and spoke with the Appellant's case manager ██████████ on ██████████ to complete her review. ██████████ stated Appellant was receiving Medicaid covered services as a child with a developmental disability. Appellant's Medicaid covered services included case management services, psychiatric services, CLS and respite services.

██████████ stated Appellant attends school full days in a small self-contained classroom in the Pathfinder program at ██████████ High School. A review of the records showed no concerns with behavior problems for the Appellant while attending school. ██████████ stated Appellant showed an increased ability with self-care. She stated he has the physical ability to care for himself he just needs some prompting.

██████████ stated Appellant's records showed the Appellant had remained medically and psychiatrically stable over the past year. The main focus of risk to Appellant was personal safety issues relating to his insomnia and the fact that he accesses the kitchen late at night and attempts to cook things which Appellant is unable to do safely. ██████████ also stated Appellant's records showed he cannot be trusted to reliably report when he is hurt, and demonstrates impaired danger awareness, insight, poor judgment/ impulse control due to his moderate mental retardation. ██████████ stated Appellant's records further showed he can be mildly defiant at home, and needs on-going supervision due to a curiosity/penchant for getting into things.

██████████ stated Appellant's respite services were reduced from ██████ hours per month down to ██████ hours per month based on a finding of a lack of medical necessity for the additional hours. ██████████ stated ██████ hours per month was not typical for individuals whose circumstances are similar to the Appellant. The ██████ hours previously authorized were set when his family situation was quite different and Appellant mother was essentially his sole caregiver. ██████████ stated Appellant's current family situation is a much better environment with his stepfather and sister able to provide additional informal supports.

██████████ was referred to the Medicaid Provider Manual and stated the decision to reduce respite services was supported by the policy that states a CMH may deny or reduce services where there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services. ██████████ stated the reduction in Appellant's respite hours is justified by the fact that the records show his behaviors are better and more consistent with what would be expected of ██████ year olds, he attends school full days, and he has a better family environment which offers a greater amount of informal supports. ██████████ acknowledged that the Appellant still needs supervision, but the intensity of his needs is reduced. ██████████ stated in her professional opinion, based upon her Utilization Management Review, with the CLS and other Medicaid services available to the Appellant the reduction in respite care does provide an appropriate level of services to meet the Appellant's current needs.

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 pursuant to its contract with the Department of Community Health. 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 *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section* dated April 1, 2013. It defines medical necessity as follows:

Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

*Medicaid Provider Manual, Mental Health /Substance Abuse, April 1, 2013, p. 5.*

The *Medicaid Provider Manual* further specifies Medical Necessity Criteria:

### **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/aids) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professions with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on personal-centered planning, and for beneficiaries with substance use disorders, individuals 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 the 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. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports 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, fate-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, April 1, 2013, pp. 12-14.*

The Medicaid Provider Manual specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

### **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**

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.

#### **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**

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.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).

### **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.

### **Productivity**

Engaged in activities that result in or lead to maintenance of or increased self sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

### **17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES**

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
- 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) 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.

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.

### **17.3 B3 SUPPORTS AND SERVICES**

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

\* \* \*

#### **17.3.J. RESPITE CARE SERVICES**

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid 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.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

*Medicaid Provider Manual, Mental Health/Substance Abuse,*  
April 1, 2013, pp. 110-114, 124.

██████████ County CMH determined to reduce Appellant's respite care and his CLS services. The Appellant appealed the reduction in respite care. The Appellant's step father submitted a number of exhibits during the hearing. (See Exhibits 1-7). In addition Appellant's sister was presented as a witness for the Appellant. Appellant's sister acknowledged that she was the Appellant's respite care provider and his CLS worker. She testified she previously worked for ██████████ an agency that previously contracted with CMH to provide Medicaid services for the Appellant.

Appellant's sister indicated she has cared for the Appellant since he was a child. She stated she doesn't believe he is stable. She indicated he is never without needs, and she would never leave him alone. Appellant's sister testified he is frequently abusive to others

and he becomes violent when he doesn't get his own way and also breaks things. She stated he engages in self-mutilation, pinching his arms and leaving bruises and visible scars. Appellant's sister also recounted a situation where he pinched a person's hand at Vacation Bible School. She indicated the Appellant is better when he is with her than when he is around the parents.

The Appellant's sister stated as a lay person she did not agree with the reduction in services. She believes the CMH records are vague and incomplete and is not surprised that based on the CMH records reviewed by ██████████ a reduction in services was proposed. The Appellant's sister acknowledged that the reduction in services would be justified based on the CMH's records, but she did not think the records were accurate or complete. She believed the records were missing significant details concerning the Appellant's behaviors. The Appellant's sister stated the Appellant's behavior was the issue, and she had witnessed assaultive behaviors that were reported to CMH, but she did not think were fully documented in the Appellant's records.

At the conclusion of the hearing, the Appellant's stepfather argued that he believed the Appellant's behavior would support an increase in services not a reduction in services. He then seemed to argue that there were many more types of services available through the CMH that could be provided to the Appellant to deal with his behavioral issues. However, the Appellant's request for a hearing, only sought to appeal the reduction in his respite care.

The Appellant bears the burden of proving by a preponderance of the evidence that additional hours of Respite Care are medically necessary. The Appellant's family was given the opportunity to prove why additional respite care was necessary. The exhibits presented during the hearing on behalf of the Appellant and the testimony of the Appellant's sister did not establish medical necessity above and beyond the number of hours of respite care the CMH assessed in accordance with the Code of Federal Regulations (CFR), based on the information contained in the Appellant's records at the time the reduction was made.

The Appellant's sister supported the CMH's decision when she testified that based upon the information contained in the Appellant's file she was not surprised with the reduction, and that the information on file if accurate would support the reduction. The position of the Appellant's family was essentially that the information in the Appellant case file was vague or incomplete and did not properly document the Appellant's behavioral issues. The Appellant's family was advised that this appeal was limited to the decision to reduce respite care that was included in the Appellant's annual plan of service on ██████████. They were further advised, if there was new or additional information that was not considered at that time, the family could provide such information to the CMH and get an updated evaluation of the Appellant's needs and the level of services that would be medically necessary to meet those needs.

The CMH must authorize respite services in accordance to the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it authorized [REDACTED] hours per month of Respite Care as "B3" services for the Appellant, in addition to the other Medicaid services the Appellant has been authorized to receive. B3 services are not intended to meet all of the Appellant's needs and preferences. Furthermore, the amount of respite hours requested is excessive. The current hours approved for Respite Care are sufficient to provide the unpaid caregivers relief on a short-term, intermittent basis, as contemplated by the policy contained in the Medicaid Provider Manual.

The Appellant failed to prove by a preponderance of the evidence that additional hours of respite care per month are medically necessary based upon the records in the Appellant's file at the time of the reduction. This ALJ concurs with the Department's determination that 24 hours per month of respite care are sufficient to meet the Appellant's needs and to give the Appellant's parents relief on a short-term, intermittent basis, as contemplated by the policy.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [REDACTED] County CMH properly reduced Appellant's respite care from [REDACTED] hours per month down to [REDACTED] hours per month based on the information CMH had at the time they made the reduction.

**IT IS THEREFORE ORDERED** that:

The Department's decision is **AFFIRMED**.

*William D Bond*

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William D. Bond  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

**\*\*\* NOTICE \*\*\***

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 Administrative Tribunal 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.

