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. 14-012685 CMH
[redacted]

[redacted]

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 [redacted], Appellant's mother/ guardian appeared and testified on the Appellant's behalf.

[redacted], Manager, Due Process and Customer Service, appeared on behalf of [redacted] (CMH or Department). [redacted], Utilization Management Coordinator, appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request for additional respite care?

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 [redacted] year-old Medicaid beneficiary (DOB [redacted]) who has been diagnosed with Mental retardation – severity unspecified and Autistic Disorder, Traumatic Brain Hemorrhage, Factor II Deficient Hemophilia, and Seizure Disorder. (Exhibit A, pp. 1, 3 and testimony).

2. [redacted] is the Community Mental Health contractor with the [redacted], (hereinafter CMH).

3. The Appellant is a participant with CMH and had been receiving Medicaid Covered Specialty Mental Health Services including [redacted] hours of respite care and supports coordination. (Exhibit B and testimony).

4. On [redacted], the CMH Utilization Management Department received a request for [redacted] hours per month of respite care for the Appellant. (Exhibit B and testimony).

5. On [redacted], CMH issued an Adequate Action Notice denying Appellant's request for [redacted] hours of respite care per month, and authorizing instead [redacted] hours of respite care per month. The reason for the denial of the additional respite care was that the documentation supported the need for [redacted] hours of respite care per month. (Exhibit A pp. 6-8 and testimony).

6. On [redacted], Appellant's request for hearing was received by MAHS. The request for hearing appealed the denial of the Appellant's request for additional respite care. (Exhibit 1).

7. In preparation for the hearing CMH reviewed the matter and determined that there was a calculation error, resulting in a change in the respite hours increasing the amount from [redacted] hours per month up to [redacted] hours per month, effective [redacted]. (Exhibit B and testimony).

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.

The CMH witness [redacted] a Utilization Management Coordinator reviewed the Appellant's Respite Assessment completed by the Appellant's Supports Coordinator [redacted] and stated she was responsible for scoring the assessment to determine the appropriate number of respite hours the Appellant should receive on a monthly basis. [redacted] stated she utilizes a scoring tool used by CMH to score all respite assessments so that each beneficiary receives the number of hours per month that are medically necessary to meet the individual's needs.

[redacted] stated the Appellant was awarded [redacted] respite hours because Appellant has only one caregiver who works part-time out of the home. Appellant was awarded [redacted] respite hours because Appellant requires [redacted] interventions per night and the time to complete the interventions is [redacted] hour or less. [redacted] stated the Appellant was awarded [redacted] respite hours because Appellant is physically abusive to others weekly, [redacted] respite hours because Appellant was physically abusive to himself weekly, [redacted] respite hours because Appellant engages in inappropriate touching daily, [redacted] respite hours because Appellant engages in public masturbation daily, [redacted] respite hours because Appellant strips in public daily, [redacted] respite hours because Appellant engages in property destruction daily, [redacted] respite hour because Appellant has temper tantrums daily, and [redacted] respite hours because Appellant wanders daily.

[redacted] stated Appellant was also awarded [redacted] respite hours because Appellant needs some assistance with toileting, [redacted] respite hours because Appellant needs total assistance for oral care, [redacted] respite hours because Appellant requires total assistance with bathing, and [redacted] respite hours because Appellant needs some assistance with dressing. [redacted] further stated Appellant was awarded [redacted] respite hours because Appellant needs total assistance with grooming, [redacted] respite hours because the Appellant is over [redacted] and needs medication administration [redacted] respite hours because Appellant is non-verbal, and [redacted] respite hours because for participation in activities the Appellant requires extensive prompting and encouragement.

[redacted] stated she came up with a total of [redacted] respite hours when she initially

scored the assessment. She sent out an Adequate Action Notice on [redacted] stating the Appellant's request for [redacted] hours of respite care per month was denied, and instead that [redacted] hours of respite care were being authorized per month. [redacted] stated the matter was reviewed prior to the hearing and it was determined there had been a calculation error resulting in a change in the respite hours, increasing the amount authorized from [redacted] hours per month up to [redacted] hours per month, effective [redacted].

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 July 1, 2014*. 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,* October 1, 2014, p. 5].

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

> **2.5.A. Medical Necessity Criteria**
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> **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,* July 1, 2014, 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) [CHANGE MADE 7/1/14]

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 [CHANGE MADE 7/1/14]

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 intellectual disability). (revised 7/1/14)

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*, July 1, 2014, pp. 119-120, 125, emphasis added].

CMH denied Appellant's request for additional respite care. The Appellant appealed the denial. The Appellant's mother/guardian testified she did not understand why only [redacted] hours of respite care were authorized per month for the Appellant. She said their circumstances have not changed. She said she has [redacted] other children at home she has to care for, and her oldest daughter is now away at college and can't help out. Appellant's mother said she is the Appellant's sole support, and she has limited assistance from other family members, including the Appellant's father who is out of state. She said she needs the same number of hours because her needs have not decreased and she is now caring for an autistic adult. The Appellant's mother acknowledged that the Appellant does attend school [redacted] through [redacted] and is out of the home from about [redacted] a.m. to [redacted] or [redacted] p.m. each school day. She said [redacted] hours of respite care had been authorized prior to her request to raise it to [redacted] hours, and she needs the respite hours to allow her to do things with her other children, and to clean up and maintain her home.

The Appellant bears the burden of proving by a preponderance of the evidence that additional respite care is medically necessary. The Appellant was given the opportunity to prove why the requested respite care was necessary. The testimony of the Appellant's mother/guardian did not establish medical necessity for the additional respite care requested, based on the information contained in the Appellant's records at the time of the denial.

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 denied the additional respite care requested for the Appellant. B3 services are not intended to meet all of the Appellant's needs and preferences. Furthermore, CMH must take into

account their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The current amount of respite care approved for the Appellant is sufficient to meet the Appellant's need for respite care and to provide the unpaid caregiver short-term, intermittent relief from daily stress and care demands, as contemplated by the policy contained in the Medicaid Provider Manual.

The Appellant failed to prove by a preponderance of the evidence that the additional respite care requested for the Appellant was medically necessary based upon the information available at the time of the denial on [redacted]. This ALJ concurs with the Department's determination that the current amount of respite care authorized for the Appellant is sufficient to meet the family's current need for respite services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant's request for additional respite services based on the information CMH had at the time of the denial.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, 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.