STATE OF MICHIGAN
MICHIGAN ADMINSITRATIVE 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:

[redacted]

Docket No. 2014-14770 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted] Appellant did not appear. [redacted], Appellant's Guardian (hereinafter Appellant or Guardian) appeared on behalf of Appellant. [redacted] appeared as a witness on behalf of Appellant.

[redacted], Attorney, represented [redacted] ([redacted]) (CMH, [redacted], or Department). The following witnesses appeared on behalf of [redacted]: [redacted], Director of Social Work; [redacted], Supports Coordinator; and Evan Cochran, Compliance Coordinator.

ISSUE

Did the [redacted] properly deny Appellant's request for additional respite Hours?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Michigan Department of Community Health (Department) subcontracts with the Department of Mental Health, who in turn subcontracts with [redacted] to provide certain Medicaid covered services to Medicaid beneficiaries who reside within their assigned area.

2. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted], who is diagnosed with a mental and developmental impairments/disability, cerebral

palsy, congenital quadriplegia, epilepsy, hearing loss, sleep issues, and myopia astigmatism. (Exhibit 1.1)

3. Appellant has chosen to receive her services through self-determination.

4. Appellant's case has the following approved hours: 12 hours per week in respite; 24 respite overnights per year; 36 hours per week in community living services; and 21 hours per week in home help services. Appellant received just under 10 hours per day of paid support.

5. On [redacted], [redacted] received a request for an increase in respite hours, from 12 to 22 per week. (Exhibit 5.1)

6. [redacted] reviewed Appellant's Individual Plan of Service (Exhibit 2), Appellant's Nursing Treatment Plan (Exhibit 3), the Periodic Review of the Individual Plan of Services (Exhibit 4), Progress Notes dated [redacted] (Exhibit 5) and a sleep study recently conducted at the [redacted] (Exhibit 3). The Department determined that the current levels of services are meet the medically necessity criteria, and, are supported by the service plans. (Exhibit 1)

7. On [redacted] [redacted] issued a notice informing Appellant that the request for an increase in hourly respite was denied as the current respite supports of 12 hours per week is sufficient to provide unpaid caregiver with a break from care. (Exhibit 1.1)

8. On [redacted], the State Office of Administrative Hearings and Rules received a hearing request, protesting the denial.

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: January 1, 2014

The definition of Respite care services can be found in the Medicaid Provider Manual, Mental Health/Substance Abuse, effective January 1, 2014:

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…. 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).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

…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 guardian/parent is protesting the denial for a requested increase in respite hours that Appellant was determined eligible to receive. Appellant's mother argued that the [redacted] sleep study was not taken into account. However, evidence shows that the sleep study was in fact taken into account, and was assessed more than once. (See for Example Exhibit 3 and Testimony). Appellant's mother also argued that the overall emotional and/or stress factors of the parent were not taken into account. However, clear and substantial evidence on the record shows that [redacted] repeatedly took into account many factors, many assessments, and the totality of the issues under numerous possible variables (See Exhibits 1-5).

Appellant's mother/representative has the burden of proving by a preponderance of evidence that the Medicaid-funded respite service increase in 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.

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 currently level of 12 hours per week and 24 overnights per year 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 denied Appellant an increase in respite services pursuant to the [redacted] notice.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: March 17, 2014

Date Mailed: March 19, 2014

***** 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.