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. 2014-35400 CMH

[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 father appeared and testified on the Appellant's behalf.

Attorney [redacted], Due Process Hearings Coordinator for [redacted], hereinafter CMH, represented the CMH. [redacted] LBSW, Respite Coordinator and [redacted], Director of Intake and Respite Services both with [redacted]), gave testimony on behalf of the CMH.

ISSUE

Did the CMH properly reduce Appellant's respite overnights from [redacted] overnights per year down to [redacted] overnights per year?

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 ([redacted] who has been receiving mental health services as a person with a developmental disability. (Exhibits A, C and testimony).

2. [redacted] is the Community Mental Health contractor with the State of Michigan, (hereinafter CMH). CMH contracts with [redacted] to provide services for individuals with developmental disabilities including supports coordination and [redacted] subcontracts with other providers who provide respite care.

3. The Appellant is a participant with CMH and had been receiving Medicaid covered services including supports coordination and [redacted] respite overnights on a self-determination basis, and supports coordination. (Exhibits A, E and testimony).

4. On [redacted] CMH determined that Appellant's respite overnights should be reduced to [redacted] per year based on medical necessity criteria, and the reduction was included in Appellant's person centered plan (PCP). (Exhibits A, E and testimony).

5. On [redacted], Appellant's request for hearing was received by MAHS. The request for hearing appealed the reduction in the number of Appellant's respite overnights. (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*].
>
> 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 witnesses provided evidence that the Appellant's Medicaid approved services had previously included supports coordination and [redacted] respite overnights. Appellant's overnight respites were reduced from [redacted] overnights down to [redacted] overnights as of [redacted]. The appeal in this case concerns the reduction in overnight respites.

[redacted], LBSW, stated she works for [redacted] as a Respite Coordinator and is the Appellant's respite coordinator. She stated she meets with the Appellant once a year to determine the need for respite. [redacted] referred to Appellant's Person Centered Plan (PCP), date of meeting [redacted] where she met with the Appellant and her parents to re-enroll her in [redacted] services. During the meeting Appellant indicated she had been bored over the past year. [redacted] again approached the idea of getting Appellant involved in community activities. [redacted] recommended that the Appellant receive increased services, but that Community Living Supports (CLS)would be more appropriate to meet the Appellant's needs to increase her involvement in community activities, to decrease her feelings of boredom and anxiety, and to allow her to become more comfortable when she is around others. [redacted] noted Appellant has demonstrated the ability to be left home alone for a minimum of [redacted] hours per day. [redacted] stated in her professional opinion [redacted] overnight respites per year are sufficient in amount, scope and duration to meet the Appellant's needs, to provide short-term, intermittent breaks to relieve family caregiver(s) from daily stress and care demands during times they are providing unpaid care, consistent with the policy quoted above.

[redacted], B.S., LBSW, stated she works for [redacted] as their Director of Intake and Respite Services. [redacted] stated she is [redacted] supervisor. [redacted] stated she reviewed the Appellant's file prior to the reduction in services, and stated that she supports the reduction in overnight respites from [redacted] down to [redacted] per year. [redacted] found in her professional opinion that the [redacted] overnight respites per year were sufficient in amount, scope and duration to meet the Appellant's needs, to provide short-term, intermittent

breaks to relieve the family caregiver(s). [redacted] stated the goals stated in the Appellant's PCP could be bet met with the [redacted] overnight respites, supports coordination, and the addition of CLS 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 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 January 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,* January 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,* January 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)**
>
> 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*, January 1, 2014, pp. 111-112, 125].

[redacted] CMH determined to reduce Appellant's respite overnight. The Appellant appealed the reduction in respite overnights. The Appellant's father testified that he did not understand the reduction in respite overnights. He urged that some of the information contained in the CMH exhibits was not correct. He said his daughter could not cook. She can only heat things up in the microwave. Appellant's father said that [redacted] was told Appellant is only left alone for two days a week, because her mother only works [redacted] hours per day [redacted] days per week. He said the Appellant's mother has more to do because she has to stay home to take care of the Appellant. Appellant's father said he doesn't agree with the reduction because the Appellant's condition is not changed, and her mother the caregiver has more work to do for the Appellant.

The Appellant bears the burden of proving by a preponderance of the evidence that additional respite overnights are medically necessary. The Appellant was given the opportunity to prove why additional respite care was necessary. The testimony of the Appellant's father did not establish medical necessity above and beyond the number of respite overnights 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. Furthermore, CMH is recommending that the Appellant receive additional services for the Appellant in the form of CLS hours which would be more appropriate to meet the Appellant's current needs, but the family is not pursuing the additional services recommended by CMH.

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 6 respite overnights per year 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 overnights requested is excessive. The current respite overnights approved for Respite Care are more than 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 respite overnights are medically necessary based upon the information available at the time of the person centered planning meeting on [redacted]. This ALJ concurs with the Department's determination that [redacted] respite overnights per year 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. The Appellant's parents are encouraged to consider utilizing the Community Living Services recommended by CMH which, in their professional opinion, are more suited to the Appellant's current needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] CMH properly reduced Appellant's respite overnights from [redacted] per year down to [redacted] per year 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
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.