STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

Date Mailed: January 5, 2017
MAHS Docket No.: 16-015899
Agency No.:
Petitioner:

**ADMINISTRATIVE LAW JUDGE:** Corey Arendt

## DECISION AND ORDER

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

After due notice, a hearing was held on January 3, 2017. , Maternal Grandmother/Adoptive Parent appeared on behalf of the Petitioner. , Maternal Grandfather/Adoptive Parent offered testimony on behalf of the Petitioner. appeared and offered testimony on behalf of (Department).

Exhibits:

| | |
|---|---|
| Petitioner | 1. Request for hearing |
| Department | A. Hearing summary |

## ISSUE

Did the Department properly reduce the Petitioner’s respite services allocation?

## 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 Department is under contract with the MDHHS to provide Medicaid covered services to people who reside in its service area. (Testimony).

2. Petitioner is a Medicaid beneficiary, who receives services through the Department. (Exhibit A, pp. 1-16; Testimony).

3. From July 1, 2012 through August 6, 2016, the Petitioner was authorized a maximum of a year for respite services. (Testimony).

4. In 2012, the Petitioner used [redacted] of the [redacted] allocated. (Testimony).

5. In 2013, the Petitioner used [redacted] of the [redacted] allocated. (Testimony).

6. In 2014, the Petitioner used [redacted] of the [redacted] allocated. (Testimony).

7. In 2015, the Petitioner used [redacted] of the [redacted] allocated. (Testimony).

8. In 2016, the Petitioner used [redacted] of the [redacted] allocated. (Testimony).

9. On August 2, 2016, a person centered planning meeting took place. During the meeting it was determined that the Petitioner's respite allocation should be reduced from [redacted] to [redacted] due to a lack medical necessity based upon prior underutilization. (Exhibit A, pp. 2-7; Testimony).

10. On August 2, 2016, notice was provided to the Petitioner regarding the respite reduction. (Testimony).

11. On November 4, 2016, the Michigan Administrative Hearing System (MAHS) received from the Petitioner a request for hearing. (Exhibit 1).

12. Petitioner's November 4, 2016 request for hearing indicated they "crossed off" over 50% of the available respite workers for one reason or another and only called the names that remained on their list. (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.]

Moreover, 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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM) articulates Medicaid policy for Michigan. The MPM states with regard to medical necessity:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> 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;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

**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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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;

    - that are 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 and Substance Abuse Chapter*
*January 1, 2016, pp 12-14*

The Department is mandated by federal regulations to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount and level of the Medicaid medically necessary services that are needed to reasonably achieve their goals.

The evidence in this case indicates there was no question as to whether or not the Petitioner was eligible for respite services; and supports the Petitioner's need for respite services. As such, the sole issue in dispute is whether or not the Department's determination as to the amount of the authorized respite services was appropriate and supported in the record.

The record in this matter and the corresponding policy, indicates the Petitioner is responsible for using the allocated respite hours as they best see fit. As such, the burden is on the Petitioner to allocate hours as needed.

The Department argued additional respite hours were not medically necessary. Specifically, the Department pointed to the fact the Petitioner at the time of the requests was utilizing about a third of the respite services being previously budgeted.

Prior utilization sets the bar as to what could be considered medically necessary. It is reasonable to assume that if there are services going unused, there is a lack of medical necessity.

Petitioner alleged the hours were not fully utilized as they had difficulty finding staff. These arguments however are a bit disingenuous given the fact they did not make an attempt to contact each and every one of the providers listed on the respite worker list. Although [redacted] indicated she did attempt to make contact with each worker listed, she later recanted after her request for hearing was read into the record and there after identified only one individual whom she had reached out to after initially crossing them off the list.

Petitioner bears the burden of proving by a preponderance of the evidence that the Petitioner was entitled to the requested respite services. The evidence presented did not meet the burden to establish medical necessity for additional respite services as the Petitioner was not fully utilizing what was already available. The assessment utilized by the Department is reasonable and appropriate and it was applied to Petitioner's needs on an individualized basis.

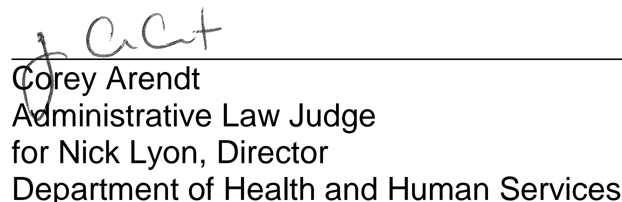
As such, the evidence presented by the Department supports the conclusions it reached with regard to the respite authorizations based on the information it had at the time the decisions were made.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced the Petitioner's respite services allocation.

**IT IS THEREFORE ORDERED** that

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



CA/sb

Corey Arendt
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

**NOTICE OF APPEAL**: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

**DHHS -Dept Contact**

**Petitioner**

**Authorized Hearing Rep.**

**DHHS Department Rep.**

**DHHS-Location Contact**