RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: January 26, 2017
MAHS Docket No.: 16-016399
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on January 10, 2017. , Petitioner's legal guardian, appeared and testified on Petitioner's behalf. Petitioner was also present during the hearing. , Chief Compliance and Fair Hearing Officer for , appeared and testified on behalf of Respondent Community Mental Health of County.

ISSUE

Did Respondent properly deny Petitioner's request for additional respite care services?

FINDINGS OF FACT

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

1. Community Mental Health of County is a Community Mental Health Services Program (CMHSP) affiliated with the , a Prepaid Inpatient Health Plan (PIHP).

2. Petitioner is a nineteen-year-old Medicaid beneficiary who has been diagnosed with obsessive-compulsive disorder; active autistic disorder; and bipolar disorder; and who has been receiving services through Community Mental Health of County. (Exhibit 2, page 2; Testimony of Respondent's representative).

3. Specifically, Petitioner has been approved for supports coordination, community living supports, and respite care services. (Exhibit A, page 7).

4. With respect to respite care services, Petitioner was approved for [redacted] of services for the plan period of October 1, 2015 through September 30, 2016. (Exhibit 1, page 7; Exhibit A, page 3).

5. On September 30, 2016, a meeting was held regarding Petitioner's plan and services for the upcoming plan year, October 1, 2016 through September 30, 2017. (Exhibit A, page 6).

6. During that meeting, Petitioner's guardian requested that additional respite care services be approved. (Testimony of Petitioner's representative).

7. However, while additional respite care services were requested, the subsequently approved plan of service again authorized [redacted] per year for respite care services. (Exhibit A, page 7).

8. On October 25, 2016, the CMH sent Petitioner a copy of the approved plan of service and notice of his appeal rights. (Exhibit A, pages 11-12; Testimony of Respondent's representative).

9. On October 28, 2016, Respondent's representative also sent Petitioner's representative a letter stating that the request for additional respite care services had been denied. (Exhibit 1, page 5; Exhibit A, page 2).

10. Regarding the specific reason for the denial, the letter stated:

> I have had an opportunity to review the information from Community Mental Health of [redacted] related to Respite services for [Petitioner]. Your son has been authorized for Respite in the amount of [redacted] annually. I have reviewed the utilization information for that service as well as the Individualized Plan of Service that was developed on 9/30/16. You have consistently (2015 and 2016) not utilized the amount of Respite authorized and as a result, it was determined that your son did not meet medical necessity criteria for additional Respite units. I also consulted the Medicaid Provider Manual as a reference.
>
> I am supporting the actions taken by Community Mental Health of [redacted] County. At this time, I am considering the matter closed. In the event that you do not agree with this determination you may request a Michigan Department of health and Human Services fair

> hearing by filling out the attached form and sending it in the enclosed envelope.

Exhibit 1, page 5
Exhibit A, page 2

11. On November 14, 2017, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that denial. (Exhibit 1, pages 1-7).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…

42 USC 1396n(b)

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 (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving respite care services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **17.3.I 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).

- 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.)

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.

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
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, 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 guardian
- 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.

MPM, July 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 132-134

Moreover, while respite care is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services

and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the MPM further provides:

> **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.

MPM, January 1, 2016 version
Mental Health/Substance Abuse Chapter, pages 13-14

Here, it is undisputed that Appellant should be approved for respite care and it is only the amount that is at issue, with Respondent continuing the authorization at [redacted] per year and Petitioner requesting additional respite care services.

In support of that decision, Respondent's representative initially testified that the request for additional respite services was denied on the basis that they were not medically necessary as Petitioner did not even use the [redacted] he had been authorized the year before. She also cited to information received from Petitioner's supports coordinator indicating that only [redacted] of respite was used between October 1, 2015 and September 30, 2016. (Exhibit A, page 3).

However, Respondent's representative later testified that other information received from the supports coordinator indicated that, rather than an underutilization, Petitioner had used over [redacted] during that plan year. (Exhibit A, page 4). She also testified that the information provided showed that Petitioner used [redacted] for respite care between October 1, 2015 and September 30, 2016, and that the CMH absorbed the extra amount because Petitioner was only allowed to go over the amount allocated due to a glitch in its billing system.

In response, Petitioner's representative/guardian testified that a usage report she received from Petitioner's fiscal intermediary indicated that Petitioner used all but [redacted] of the [redacted] respite budget for the plan year of October 2015 through September 2016. (Exhibit 1, page 7). She also conceded that [redacted] of that amount was used in September of 2016, which was the month before the plan expired, but stated that the family likes to save the respite care and use it all at once if possible. Petitioner's representative further testified that Petitioner was diagnosed with bipolar disorder during the past year and is becoming more difficult to care for.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for additional respite care services.

Given the record in this case, Petitioner has met that burden of proof and the Respondent's decision should therefore be reversed. Respondent denied the request for additional respite on the basis that Petitioner was already underutilizing what he had been approved for, but Petitioner's credibly demonstrated that there was no significant

underutilization in the most recent plan year. Moreover, the evidence cited by Respondent in support of the denial is conflicting at best, with some information expressly stating that, rather than underutilizing his respite, Petitioner actually used significantly more respite than what was approved.

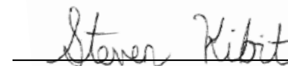
It is not clear that the additional respite care hours are medically necessary, with the fact that Petitioner went months without using any respite and that the majority were used right before the plan expired suggesting that they are not, though Petitioner's representative did credibly testify that Petitioner's family likes to save the respite and use it all at once if possible. However, what is clear is that Petitioner has met his burden of showing that Respondent erred in denying his request. Accordingly, Respondent's decision is reversed and it must reassess Petitioner's request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for additional respite care services.

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED** and it must initiate a reassessment of Petitioner's request for respite care services.



SK/tm

Steven Kibit
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

Authorized Hearing Rep.

DHHS -Dept Contact

Petitioner

DHHS Department Rep.

DHHS-Location Contact