[redacted]
MI [redacted]

Date Mailed: October 20, 2020
MOAHR Docket No.: 20-003264
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

On September 15, 2020, an Order and Briefing Schedule was issued instructing the parties that this matter would be decided on the evidence previously submitted plus additional evidence to be submitted by the parties by October 2, 2020. Both parties submitted additional evidence and arguments by the due date.

[redacted] and [redacted] Petitioner's parents, represented Petitioner, [redacted]

Stacy Coleman-Ax, Fair Hearing Officer, represented Respondent, Macomb County Community Mental Health (CMH).

EXHIBITS

Petitioner's Exhibits:

Exhibit 1: Request for Hearing, pp 1-36

Exhibit 2: Petitioner's Written Argument, pp 1-3

Exhibit 3: Petitioner's Response to Respondent's Written Argument, pp 1-13

Exhibit 4: Testimony (all cases), and Attachments, pp 1-39

Respondent's Exhibits:

Exhibit A: Hearing Summary, pp 1-14

Exhibit B: Respondent's Written Argument and Attachments, pp 1-47

Exhibit C: Respondent's Response to Petitioner's Written Argument, p 1

ISSUE

Did the CMH properly reduce Petitioner's 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. Petitioner is a [redacted]-year-old Medicaid beneficiary, born July 1, 1991, receiving services through Macomb County Community Mental Health (CMH). (Exhibit B, p 6)

2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A)

3. Petitioner resides in single family home with his parents and brother. (Exhibit B, p 7)

4. Petitioner is diagnosed with autism spectrum disorder, intellectual disability, obsessive-compulsive disorder, posttraumatic stress disorder, attention-deficit/hyperactivity disorder, unspecified anxiety disorder, other specified disorders involving the immune mechanism. (Exhibit B, p 32)

5. Petitioner participates in the HAB Waiver and receives CLS, Respite, Supports Coordination, Enhanced Pharmacy, Goods and Services, Speech Therapy, Massage Therapy (private), Self-Determination, and Behavioral Services. (Exhibit B, p 14)

6. Petitioner is a high school graduate and has obtained an Associate Degree from Macomb Community College. Petitioner participated in special education programs in elementary and high school and required extensive one on one assistance to attend community college. (Exhibit B, pp 14-15)

7. Petitioner has substantial functional limitations in the areas of self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency. (Exhibit B, p 31)

8. On July 19, 2019, CMH conducted the annual assessment that was in effect at the time the action in this matter was taken. (Exhibit A, pp 6-42; Testimony)

9. On January 16, 2020, CMH received a request for respite services for Petitioner to continue at the previously authorized rate of five hours per

day. (Exhibit B, p 1)

10. Petitioner also receives 14 hours of Community Living Supports (CLS) per day and an average of 2.25 hours of Adult Home Help per day. (Exhibit B, p 1)

11. Following a review of Petitioner's needs, CMH reduced Petitioner's respite from five hours per day to one hour per day. (Exhibit A, pp 1-2)

12. On January 27, 2020, CMH sent Petitioner a Notice of Adverse Benefit Determination indicating that the request for five hours of respite per day was denied but that one hour per day of respite had been approved. (Exhibit A, pp 2-5; Testimony)

13. On February 28, 2020, following an internal appeal, CMH sent Petitioner a Notice of Appeal Denial, which upheld the reduction in respite. (Exhibit A, pp 1, 53-54; Testimony)

14. On March 5, 2020, Petitioner filed a request for hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). On May 8, 2020, Petitioner refiled the request for hearing when informed by MOAHR that it had no record of receiving the March 5, 2020 appeal. (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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. 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.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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; 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.

- 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; 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
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 14-16

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from

the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

****

15.1 WAIVER SUPPORTS AND SERVICES

****

Respite Care Respite care services are provided to a waiver eligible beneficiary 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. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "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 periods 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.

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 full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
- Group home; or
- Licensed respite care facility.
- Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

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. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 106, 121-122

Emphasis added.

CMH argues that five hours per day of respite does not fit into the MPM definition of respite as being short-term and intermittent. CMH also points out that five hours of respite per day is significantly more respite than Petitioner received under the Children's Waiver. CMH argues that Petitioner receives 14 hours of CLS per day, plus 2.25 hours per day of AHH, so with five hours of respite added on, that would equate to 21.25 hours of paid care per day. CMH argues that while it was noted in Petitioner's last assessment that his sleep time had decreased, he still must sleep at times, and Petitioner's parents and brother could get a break from care during this time. CMH argues that with the one hour per day of respite authorized, Petitioner would still be receiving 17.25 hours of paid care per day, leaving only 7.75 hours per day when Petitioner does not have paid supports. CMH points out that Petitioner's parents and brother are all paid caregivers in the home and that the utilization patterns for respite between August 5, 2019 and May 8, 2020 show a consistent usage of respite that is neither temporary nor intermittent. (Exhibit B, pp 44-47)

Petitioner argues that the respite services were not continued during this appeal even though Petitioner requested that they be continued. Petitioner also points out that he lost one respite worker during this appeal because the worker was not paid by CMH in July 2020. Petitioner argues that this drastic cut in respite (80%) was made during the mid-point of Petitioner's Person Centered Plan/IPOS and ALJ Kibit had previously ruled that the CMH could not make such cuts mid-plan without a full assessment. Petitioner argues that he needs 24/7 care and these respite hours are necessary to keep him safe, especially during the pandemic. Petitioner argues that his respite authorization has never been this low (one hour per day) since he has been receiving services through the HAB Waiver. In fact, Petitioner argues that his respite hours have increased gradually over the past three years due to his complex medical needs. Petitioner argues that these services have been justified as medically necessary in the past and nothing changed in Petitioner's needs in January 2020. In fact, Petitioner argues that his needs had actually increased prior to the cut in respite.

Petitioner also argues that CMH's referral to respite under the Children's Waiver is inappropriate because under the Children's Waiver it is expected that parents of minor children will provide some care to their children, but there is no such expectation for adults under the HAB Waiver. Petitioner argues that CMH cannot reduce the scope, length and duration of services if they have been deemed medically necessary. CMH argues that CMH has not shown that the five hours of respite per day are not needed or that those respite hours do not meet the definition of respite under the MPM. Petitioner argues that living in one's family home does not decrease Petitioner's need for services given that he still requires 24/7 sightline supervision.

Petitioner further argues that CMH misstated the amount of AAH he was receiving at the time of the denial and, in fact, Petitioner was only receiving 51 hours of AHH per month at that time, or approximately 1.7 hours per day. Petitioner also argues that CMH's assertion that Petitioner will only be without paid care 7.75 hours per day if this cut is upheld is incorrect because that assumes that Petitioner is able to use all his

authorized services. Petitioner points out that this is rarely the case as staffing shortages have affected Petitioner and he rarely is able to use all his services. Petitioner argues that contrary to CMH's assertion, the family cannot get a break when Petitioner sleeps because his sleeping patterns are so varied. Petitioner also points out that his father works different shifts, so he needs to sleep at different times of the day. Petitioner also points out that respite is not always a time for his family to take a break as respite time is used by family members to maintain the home, prepare meals, for shopping, and coordinating Petitioner's care.

Petitioner also argues that CMH's reliance on the pattern of use of respite by Petitioner to support the cut in services is improper and should not be utilized to determine the scope, duration, or length of service. Even so, Petitioner argues that the pattern of use actually supports the fact that the respite is being used on a temporary and intermittent basis. For example, Petitioner points out that respite was used only ten days in September 2019, twenty days in March 2020, and only three days in May 2020. Petitioner argues that five hours of respite per day meets the definitions of "short-term" and "intermediate" when a person needs 24/7 care and daily stressors exist. Petitioner also argues that CMH's contention that only Petitioner's father works outside of the home is incorrect as all three family members work outside the home at times. Petitioner also points to MSA Bulletin 20-58, dated September 17, 2020, effective March 10, 2020, which suspends caps on limits on Respite during the COVID-19 pandemic. Petitioner also argues that CMH's action in this matter violates the U.S. Supreme Court's ruling in *Olmstead v L.C.*, 527 US 581 (1999) by placing obstacles in Petitioner's way and failing to ensure that Petitioner receives the supports and services he needs in the most integrated setting.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in reducing his respite services from five hours per day to one hour per day. Based on the evidence presented, Petitioner has met that burden.

As indicated above, respite services may be 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." According to policy, short term means, ". . . 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 periods in between." Primary caregivers "are typically the same people who provide at least some unpaid supports daily." And unpaid means "that respite may only be provided during those portions of the day when no one is being paid to provide the care."

Here, Petitioner is authorized to receive 35 hours of respite per week, or an average of five hours of respite every day, 365 days per year. While one could argue that five hours is "short-term", as in a "limited period of time" when compared to the 24 hours of care per day Petitioner requires, five hours per day, every day can in no way be considered intermittent. Clearly, five hours of respite per day, every day, is regular and continuous. And, while there is a break of 19 hours in between each respite service, the fact that the same pattern repeats itself every day is regular and continuous.

However, as improper as the respite authorization may have been, the CMH cannot simply reduce respite by 80% in the middle of a one-year IPOS agreement without doing a more thorough analysis of Petitioner's needs. Here, CMH properly identified that Petitioner's respite authorization was improper, but it did no assessment of how removing four care hours per day from Petitioner's agreed upon plan of service would affect Petitioner. All CMH did was list the other services Petitioner was authorized to receive and conclude, basically, "he will be fine." Clearly there was a reason that Petitioner was previously authorized to receive 21.25 hours of care per day between CLS, AHH, and respite. Nothing changed in the middle of Petitioner's agreed upon plan of service except that the CMH noticed that it was likely using respite improperly in Petitioner's case. When that occurs, a full assessment involving all parties must be conducted before CMH can unilaterally reduce one of those services by 80%.

As such, CMH's decision was improper and must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly reduced Petitioner's respite.

IT IS THEREFORE ORDERED that:

The CMH decision is REVERSED.

Within 10 days of this Order, CMH must certify that it has taken steps to begin a reassessment of Petitioner's need for respite services in conjunction with his other authorized services.

RM/sb

Robert J. Meade
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
48913

Authorized Hearing Rep.

[redacted] MI [redacted]

DHHS-Location Contact

David Pankotai
Macomb County CMHSP
22550 Hall Road
Clinton Township, MI
48036

Petitioner

[redacted] MI

Agency Representative

Stacy Coleman
Macomb County CMHSP
22550 Hall Rd.,
Clinton Township, MI 48026
stacy.coleman@mccmh.net

Counsel for Respondent

Tracy Dunton, M.A. LPC
6555 15 Mile Road
Sterling Heights, MI
48312
Tracy.Dunton@mccmh.net