[redacted]
MI [redacted]

Date Mailed: December 2, 2021
MOAHR Docket No.: 21-004955
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.

After due notice, a hearing was held on November 30, 2021. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf.

Dorian Johnson, Due Process Manager and Fair Hearing Officer, appeared and testified on behalf of Respondent, The Detroit Wayne Integrated Health Network. (Respondent, CMH or DWIHN.) Susan Gardner, DWIHN Appeals Specialist; and Brandi Marable, DWIHN Appeals Specialist; appeared as a witness for the CMH. Attorney Chandra Cozart appeared on behalf of CMH's contracted provider, Community Living Services, Inc. (CLS). Audrya Roquemore, Director of Community Supports, CLS and Debra Plowden, Director of Customer Service and Intake, CLS, appeared as witnesses.

ISSUE

Did the CMH properly authorize 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 an [redacted]year-old Medicaid beneficiary, born [redacted], who has been receiving services through DWIHN since September 3, 2021. Prior to September 3, 2021, Petitioner received community mental health supports and services through Oakland County, where the family previously lived. (Exhibit A, p 11; Testimony)

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; Testimony)

3. Petitioner resides in a single-family home with his mother and two minor siblings, aged [redacted] and [redacted]. (Exhibit A, p 11; Testimony)

4. Petitioner is diagnosed with legal blindness, Atypical Rett Syndrome, Cerebral Palsy, quadriplegia, epilepsy, spasticity, central sleep apnea, dysphagia, gastroesophageal reflux disease, and bilateral hypertropia. (Exhibit A, p 11; Testimony)

5. Petitioner is tracheostomy dependent with ventilator support and has flexion contracture of the knee and contracture of multiple joints. Petitioner has a gastrostomy tube and is fed via an electronic pump for an average of six hours per day. Petitioner has a history of acidosis, chronic respiratory failure with hypoxia and hypercapnia. Petitioner weighs approximately 21 pounds and uses an adaptive wheelchair stroller that can meet his mobility needs. Petitioner receives oxygen in case of emergency. Petitioner is totally dependent on others in all areas of care including ambulation, dressing, hygiene, grooming and eating. (Exhibit A, p 11; Testimony)

6. Petitioner's Ashton Rett Syndrome causes him to move his head back and forth, which causes his ventilator tube to come lose and the alarm to sound. Petitioner must be monitored closely so that he does not dislocate the ventilator tube. (Exhibit A, p 11; Testimony)

7. Due to risk of infection from the COVID-19 pandemic, Petitioner is home schooled. (Exhibit A, p 51; Testimony)

8. At his IPOS meeting on September 3, 2021, Petitioner's mother requested that the 60 hours per week of respite that Petitioner had been receiving through Oakland County CMH be continued with the move to Wayne County. The requested respite was so high because, even though Petitioner has been approved for 12 hours of PDN daily through Children's Special Health Care Services (CSHCS), no nursing staff have been found to fill the hours due to staffing issues due to COVID-19. Petitioner's mother had found two respite providers whom she was able to train enough to at least help monitor Petitioner until PDN staff can be found. (Exhibit A, p 11; 39, 45-50; Testimony)

9. Following the IPOS meeting, CMH approved Petitioner for the following supports and services: Supports Coordination in the amount of one hour per month, Fiscal Intermediary Services; and Respite Services in the amount of 24 hours per month. (Exhibit A, p 7, 15-17; Testimony)

10. On September 10, 2021, CMH sent Petitioner an Adequate Notice of Adverse Benefit Determination reflecting the reduced amount of respite

approved (24 hours per month). (Exhibit A, pp 21-27)

11. On September 15, 2021, Petitioner's mother filed a request for a local appeal, which included an outline of the Plan of Care that Petitioner follows every day. (Exhibit A, pp 45-50)

12. On September 17, 2021, the Owner / Director of Clinical Services at First Day Homecare authored a To Whom it May Concern Letter, confirming that Petitioner has been on the waiting list for a PDN provider since June 29, 2020. (Exhibit A, p 39; Testimony)

13. On October 7, 2021, CMH sent Petitioner's appeal for review by its Chief Medical Officer (Psychiatrist), who supported the decision to authorize only 24 hours per month of respite. (Exhibit A, pp 35-37; Testimony)

14. On October 8, 2021, following a local appeal, CMH sent Petitioner a Notice of Appeal Denial, which upheld the reduced authorization of respite. (Exhibit A, pp 28-33; Testimony).

15. On October 22, 2021, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit A, pp 2-3)

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
July 1, 2021, pp 12-14

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. MDHHS 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.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 childcare home

Respite care may not be provided in:

- day program settings
- ICF/IID's, 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.

Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter
July 1, 2021, pp 120, 133-134
Emphasis added.

CMH argues that the authorization of respite services was proper here because Petitioner is authorized to receive 12 PDN hours per day, and given the parent's responsibility to provide eight hours of care a day, the amount of respite requested would result in more care giving hours being authorized than there are hours in the day. CMH points to the above policy in support, including the fact that respite is meant to provide short-term and intermittent breaks to a beneficiary's primary caregiver, not as a substitute for direct care. CMH also points out that since the authorization on September 3, 2021, Petitioner's mother has not used any of the authorized respite, which, CMH argues, also supports the reduction in services here.

Petitioner's mother argues that the only reason she is requesting so much respite, and was authorized for so much respite in Oakland County, is that no one has been able to fulfill the 12 hours of PDN per day due to staffing issues with the COVID-19 pandemic. Petitioner's mother points out that she is just trying to keep Petitioner alive during the pandemic and she cannot do so alone. Petitioner's mother explained that the reason she has not used any respite since the authorization was lowered in September 2021 is that her respite providers were not able to continue given the huge reduction is authorized respite. Petitioner's mother indicated that she believes she will be able to get at least one of those respite providers back if the respite is reinstated at the previous levels.

Petitioner bears the burden of proving by a preponderance of the evidence that 60 respite hours per week are medically necessary. Based on the evidence presented, Petitioner has proven by a preponderance of the evidence that 60 respite hours per week are medically necessary.

As CMH correctly points out, B3 services are not intended to meet all of a consumer's needs and preferences and the CMH must consider its ability to serve other beneficiaries. The CMH must also consider the availability of informal supports. Here, however, while Petitioner is authorized to receive 12 PDN hours per day, Petitioner's mother has not been able to find staffing for those hours due to staffing shortages relating to the COVID-19 pandemic. Petitioner's mother explained that she and her support coordinator have checked with all the staffing agencies in the area, and continue to check daily, but no staffing is available. Of course, respite is not mean to be a long-term care solution but rather, as the policy above indicates, respite is 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 . . ." However, under the present circumstances, respite is apparently the only service

available to keep Petitioner alive until the PDN hours can be fully staffed.[1] Of course, once that occurs, it would be proper to reduce Petitioner's respite. As such, based on the evidence presented, the CMH's decision was improper and should be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly denied Petitioner's request for 60 hours of respite per week.

IT IS THEREFORE ORDERED that:

The CMH decision is REVERSED.

Within 10 days of the issuance of this Order, CMH must certify that it has reinstated Petitioner's respite at the prior authorized rate of 60 hours per week until such time as Petitioner's PDN services can be staffed.

RM/sb

Robert J. Meade
Administrative Law Judge

[1] If there is a more appropriate service available, CMH is free to authorize that service. CMH's support coordinator is also free to work with Petitioner's case manager through CSHCS to find appropriate support to monitor and care for Petitioner until the PDN hours can be staffed.

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

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