STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON I. BROWN
DIRECTOR

[redacted]

Date Mailed: April 18, 2024
MOAHR Docket No.: 24-002193
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on March 28, 2024. [redacted] Petitioner's father, appeared and testified on the minor Petitioner's behalf.[1] Stacy Coleman, Consultant, appeared and testified on behalf of Respondent Macomb County Community Mental Health (Respondent).

During the hearing, Petitioner's request for hearing was entered into the record without objection as Exhibit #1, pages 1-12. Respondent also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-83.

ISSUE

Did Respondent properly deny in part Petitioner's request for 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. Petitioner is a twelve (12) year-old Medicaid beneficiary who has been diagnosed with cerebral palsy; Lennox-Gastaut Syndrome with intractable seizures; development delays; impaired airway clearance; and torticollis. (Exhibit #1, pages 3-5; Exhibit A, page 39).

[1] Prior to the hearing, MOAHR received a request from Respondent for an interpreter for Petitioner's representative, who had not requested one in the request for hearing. On the record at the hearing, the undersigned Administrative Law Judge offered to adjourn the hearing so that an interpreter could be arranged, but Petitioner's representative stated that none was needed and that he wanted to proceed.

2. She requires multiple medications; a respiratory treatment schedule; and a g-tube for medications and feedings. (Exhibit #1, pages 3-5; Exhibit A, page 43-44, 47).

3. She lives with her parents, who are her natural supports. (Exhibit A, pages 39-41; Testimony of Petitioner's representative).

4. Petitioner is completely dependent on others and relies on supports for all her activities of daily living and instrumental activities of daily living. (Exhibit A, pages 48-49, 64-68; Testimony of Petitioner's representative).

5. Due to her diagnoses and need for assistance, Petitioner has been approved for services with Respondent. (Exhibit #1, page 2; Testimony of Petitioner's representative).

6. Specific services have included targeted care management; respite care services; occupational therapy; and physical therapy. (Exhibit A, page 49; Testimony of Respondent's representative).

7. Prior to the action at issue in this case, Petitioner was approved for twelve (12) hours per week of respite care services. (Exhibit #1, page 2; Exhibit A, pages 36-37).

8. The respite has been provided by a nurse, though that was not specifically approved by Respondent. (Exhibit #1, page 2; Exhibit A, pages 25-37; Testimony of Respondent's representative).

9. On November 14, 2022, Respondent completed an Annual Assessment with respect to Petitioner. (Exhibit A, pages 39-71).

10. In that assessment, it was noted that Petitioner uses a nurse for respite, who helps with checking diapers, giving medications, checking vitals, assisting with activities of daily living, and addressing any medical needs. (Exhibit A, page 49).

11. On December 19, 2023, a person-centered plan (PCP) was held for the purpose of addressing Petitioner's needs and services for the upcoming plan year. (Exhibit A, pages 72-83).

12. Goal #6 in the proposed PCP identified Petitioner's father as reporting:

> We need the nurse to help [Petitioner]. Everything is difficult for one person such as to give [Petitioner] showers are for her health to make her feel good and to be clean. Sometimes need help with [Petitioner's] tube replacement. [Petitioner] is getting bigger and it is getting harder to care for her alone.

Exhibit A, page 76

13. The proposed PCP also provided that Petitioner will receive nursing respite to help address her medical needs, and it recommended an increase to 36 hours per week of respite care services. (Exhibit A, page 76),

14. Petitioner's representative also later identified the request as being for at least 36 hours per week of respite care with a nurse (Exhibit #1, page 2; Testimony of Petitioner's representative).

15. Respondent identified the request as being for 24 hours per week of nursing respite. (Exhibit A, page 2; Testimony of Respondent's representative).

16. On December 26, 2023, Respondent sent Petitioner a written Adverse Benefit Determination stating that the request for 24 hours per week of nursing respite care services had been denied because the service was not medically necessary. (Exhibit A, pages 2-15).

17. On January 4, 2024, Petitioner filed an Internal Appeal with Respondent in response to that Notice of Adverse Benefit Determination. (Exhibit A, page 16).

18. On February 19, 2024, Respondent sent Petitioner a written Notice of Appeal Denial stating that the Internal Appeal had been denied and that the decision to only approve 12 hours per week of respite care services was being upheld. (Exhibit #1, pages 6-11; Exhibit A, pages 16-21).

19. With respect to the reason for that decision, the Notice of Appeal Denial stated:

> You asked for 12 hours per week of Respite using a Nursing Agency for the date range 12/19/23-2/7/24. This was denied for a lack of medical necessity. [Petitioner] has not been approved for Respite using a Nursing Agency in the past after reviewing his [sic] recent plan of service and annual assessment compared to the criteria for Private Duty Nursing in the Medicaid Provider Manual and the Macomb County Community Mental Health Policy. You also asked for an increase in Respite hours in the amount of 24 hours for the time frame of 12/19/23-12/18/24. There is no proof that there was a change in [Petitioner's] needs to support the request for more Respite. There was a lack of medical necessity to support the increase. The approvals for the previous year of 12 hours per week of Respite will be continued for the time frame of 12/19/24-6/19/24. The agency that provides your Respite services has been using a higher level of care (nursing) for the Respite even though the Respite had not been approved as Respite with a nurse.
>
> *Exhibit #1, page 6*
> *Exhibit A, page 16*

20. Petitioner was then approved for 12 hours per week of respite again, with a nurse temporarily as she transitions. (Exhibit A, page 38; Testimony of Respondent's representative).

21. On March 6, 2024, MOAHR received the request for hearing filed in this matter with respect to Petitioner's respite care services. (Exhibit #1, pages 1-12).

22. Along with that request for hearing, Petitioner included letters from medical providers drafted after the appeal decision in which those providers opined that Petitioner needed trained nursing care. (Exhibit #1, pages 3-5).

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)) (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, and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **17.4.G. RESPITE CARE SERVICES [RE-NUMBERED & CHANGES MADE 4/1/23]**
>
> 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, CLS, 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 CLS 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., CLS) or service through other programs (e.g., school).

- Beneficiaries 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 beneficiary 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.)

If an adult beneficiary living at home is receiving home help services and has hired **(revised per bulletin MMP 22-36)** 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
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- nursing homes
- 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, October 1, 2023 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 155-156
(Internal highlighting omitted)

While respite care services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also 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, October 1, 2023 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 13-15*

Moreover, regarding State Plan Amendment (SPA) support and services like respite care, the MPM further states in part:

> **17.2 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF BEHAVIORAL HEALTH 1915(I) STATE PLAN AMENDMENT (SPA) SUPPORTS AND SERVICES [RE-NUMBERED, TITLE REVISED & CHANGES MADE 4/1/23]**
>
> 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 BH 1915(i) SPA 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 ensure 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 BH 1915(i) SPA 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 their community; and without such services and supports, would be impossible to attain.
>
> * * *

17.3 CRITERIA FOR AUTHORIZING BH 1915(I) SPA SUPPORTS AND SERVICES [RE-NUMBERED, TITLE REVISED & CHANGES MADE 4/1/23]

The authorization and use of Medicaid funds for any of the BH 1915(i) SPA 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;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's individual plan of service; and
- Additional criteria indicated in certain BH 1915(i) SPA service definitions, as applicable.

Decisions regarding the authorization of a BH 1915(i) SPA 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 BH 1915(i) SPA 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 their 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.
>
> Refer to the Behavioral Health Code Charts and Provider Qualifications document for supports and services provider qualifications. The Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. (Refer to the Directory Appendix for website information.) **(revised per bulletin MMP 22-36)**
>
> *MPM, April 1, 2023 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 145-147*
> *(internal highlighting omitted)*

Here, as discussed above, Petitioner requested an increase in respite care services, with the respite to be provided by a nurse; Respondent denied that request and only reapproved 12 hours per week of regular respite care; and Petitioner appealed that decision.

In support of Respondent's decision, its representative testified that Petitioner has repeatedly been approved for respite care services in the past, but not in the increased amount Petitioner now seeks and not with a nurse providing the services, though it appears that a nurse had been providing the care. She also testified that Petitioner's needs are being met, with no changes warranting an increase in services and nothing in the record at the time of the decision indicating a need for nursing respite.

In response, Petitioner's representative/father testified that Petitioner has terrible health conditions and requires a significant amount of care; and that they are requesting the amount of nursing respite recommended by Petitioner's doctor. He also testified that Petitioner is quite healthy right now, but that she is getting older and needs more care; and that they want increased respite to adjust the caregivers shifts and provide care 4 days a week. He further testified that he and Petitioner's mother are not nurses, but they have learned a lot from a nurse and that is why they are able to care for Petitioner. Petitioner's representative did concede that they would welcome any caregiver that has the knowledge to care for Petitioner, but that Petitioner also deserves the best.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner's parents undisputedly provide a significant amount of unpaid care to their minor daughter, but Petitioner also continues to be authorized for a substantial amount of respite care, *i.e.,* 12 hours per week, and the authorization appears to be sufficient to provide Petitioner's natural supports with short-term, intermittent relief from the daily stress and care demands during times when they are providing unpaid care,

Petitioner was previously authorized for the same amount of respite care services that Respondent has reapproved, and the record does not reflect any decline in Petitioner's conditions or significant needs that would necessitate a change in those services. Moreover, while Petitioner undisputedly has significant care needs, which also undoubtedly cause stress to Petitioner's primary caregivers, Petitioner and her representative appear to be seeking respite care as a regular part of her routine care, with no real discussion of a need for a break, when such continuous and long-term services are not the goal or role of respite. Additionally, the above policies further provide that BH 1915(i) SPA supports and services like respite are not intended to meet all an individual's needs and preferences, as some needs may be better met by community and other natural supports, and that 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.

Similarly, the record does not support the request for nursing respite, with no documentation suggesting a need for nursing services as part of respite care. Petitioner's parents, who are not medical providers, are able to provide the necessary care and even Petitioner's representative conceded during the hearing that they would be fine with non-nurses providing care, so long as they were sufficiently trained. At most, the letters from Petitioner's medical providers, which were not available at the time of the decision in this case, suggest a need for routine nursing care without any discussion of respite or a break for Petitioner's parents.

Petitioner has targeted case management and, to the extent Petitioner's representative believes Petitioner requires ongoing, routine private duty nursing services, the undersigned Administrative Law Judge would encourage him to discuss options for requesting such services as a Medicaid benefit with Petitioner's case manager. *See* MPM, April 1, 2024 version, Private Duty Nursing Chapter.

Moreover, to the extent Petitioner's representative has additional or updated information to provide regarding Petitioner's need for respite care, in an increased amount and/or with a nurse, then Petitioner's representative can always request additional services in the future along with that information.

With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 18th day of April 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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