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 23, 2024
MOAHR Docket No.: 24-002679
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 April 18, 2024. [redacted] Petitioner's mother and guardian, appeared and testified on Petitioner's behalf.

Katherine Squire, Fair Hearing Officer, appeared and testified on behalf of Respondent, Community Mental Health for Central Michigan. (Respondent or CMH.) Angela Zywicki, Utilization Management and April Higgins, Provider Manager, appeared as witnesses for Respondent.

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 a Medicaid beneficiary who has been receiving services through CMH. (Exhibit A; 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 her parents and siblings. (Exhibit A, p 19; Testimony)

4. Petitioner is diagnosed with autism spectrum disorder; down syndrome, unspecified; intellectual disability – severe; and speech and language development delay due to hearing loss. (Exhibit A, p 28; Testimony)

5. Petitioner has moderate limitations in self-care and requires repeated reminders and prompting to complete tasks. Petitioner has severe limitations in receptive/expressive language, partially due to severe hearing loss. Petitioner has severe limitations in learning and attended special education until just before her 18th birthday. Petitioner has mild limitations in mobility, and severe limitations in self-direction and capacity for independent living, and economic self-sufficiency. (Exhibit A, p 29; Testimony)

6. On February 12, 2024, following a Person Centered Planning (PCP) meeting, a request to continue 53.5 hours per month of respite was submitted. (Exhibit A, pp 32-47; Testimony.)

7. On February 23, 2024, CMH completed a utilization review of Petitioner's respite request. (Exhibit A, pp 15-17; Testimony.)

8. On February 27, 2024, CMH sent Petitioner an Adverse Benefit Determination indicating that only 25 hours per month of respite was approved as medically necessary. (Exhibit A, pp 3-8; Testimony.) Specifically, the notice indicated, in relevant part:

> 53.5 hours per month of Respite services were requested and medical necessity for the service has not been established based on clinical documentation available. The amount of respite is being decreased, the Psychosocial assessment, Person Centered Plan, Level of Care grid and progress notes were reviewed when making this determination. If you have a change in circumstances[,] please follow up with your CMHCM case manager to discuss service needs.
>
> (Exhibit A, p 3.)

9. On March 5, 2024, Petitioner filed a request for a local appeal. (Testimony.)

10. On March 12, 2024, following the internal appeal, CMH sent Petitioner a Notice of Appeal Denial, which upheld the original reduction in respite. (Exhibit A, pp 9-14; Testimony.) Specifically, the notice indicated in relevant part:

> Your Internal Appeal was denied for the service/item listed above because:

> After reviewing your chart and the Medicaid Manual the recommendation of 25 hours of respite per month is supported. Respite is not to be used weekly and is meant for intermittent break for the primary caregiver; as well as not to be used during staff sleeping time. When looking at her hours of paid support and sleeping hours per week
>
> 55 hrs/week CLS
>
> 32 hrs/week AHH
>
> 6 hrs night sleeping
>
> This leaves 39 hrs a week (6.5 hrs day) of natural support time. 25 hrs/month would allow the occasional date nights, relaxation or time with others. With that said, it is recommended a step down takes place over the next 3 months to assure smooth transition for family to adjust.
>
> For example:
>
> March-April- 45 hrs/mo respite
>
> April-May-35 hrs/mo respite
>
> May-June-25 hrs/mo respite
>
> (Exhibit A, p 9.)

11. On March 20, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (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, 2024, pp 13-15

17.3 CRITERIA FOR AUTHORIZING BH 1915(I) SPA SUPPORTS AND SERVICES

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.)

17.4 BH 1915(I) SPA SUPPORTS AND SERVICES

The BH 1915(i) SPA supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

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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).

- 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 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2024, pp 149-150, 157-159
Emphasis added.

CMH argued that it properly reduced Petitioner's respite after a comprehensive review of Petitioner's chart, including the past usage of respite, as well as a consultation with Petitioner's treatment team and Petitioner's parent. CMH pointed out that a review of Petitioner's recent use of respite did not fit into the above policy requirements of being short-term and intermittent. Specifically, CMH found that in January 2024, Petitioner used respite on 17 of 31 days in the month and in February 2024, Petitioner used respite on 25 of 29 days of the month. CMH also noted that a review of Petitioner's use of respite for 2023 found that Petitioner had 152 unutilized respite hours. CMH also pointed out that Petitioner receives 55 hours a week of CLS and 32 hours of Adult Home Help (AHH) a week, plus Petitioner sleeps 6 hours per night, leaving approximately 39 hours per week, or 6.5 hours per day, for natural supports to care for Petitioner.

Petitioner's mother argued that Petitioner requires 24/7 care and assistance and cannot be left alone even for a minute. Petitioner's mother indicated that Petitioner has no concept of safety and would get into a vehicle with anyone. Petitioner's mother indicated that reducing Petitioner's respite would add to the stress and exhaustion in

their lives due to caring for Petitioner. Petitioner's mother also pointed out that Petitioner no longer receives 32 hours of AHH as that service has also been reduced (from 138.57 hours per month to 85.55 hours per month). Petitioner's mother noted that Petitioner does not sleep six hours per night due to insomnia and they are lucky if she sleeps two hours per night. Petitioner's mother argued that the use of respite in January and February was due to the fact that they were not able to use the respite for longer outings during those months because Petitioner had had three foot surgeries and they were home with her 12 weeks straight. Petitioner's mother indicated that they usually use respite per Medicaid policy, by going to church with the family every other week, going on vacations, having the occassional date-night, and occassional outings with friends and family. Petitioner's mother also pointed out that she and her husband both work full-time and have to use respite to take yearly classes and attend conventions so they can keep their jobs.

Petitioner bears the burden of proving by a preponderance of the evidence that 53.5 respite hours per week are medically necessary. Based on the evidence presented, Petitioner has failed to prove by a preponderance of the evidence that 53.5 respite hours per week are medically necessary.

As CMH correctly points out, BH 1915(I) SPA 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, Petitioner's parents did not use respite according to Medicaid policy in January and February 2024 and Petitioner's parents had 152 hours of respite that went unused in 2023.

As indicated above, "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). And "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between. Here, Petitioner's parents use respite to attend church twice per month so that they can fully engage in the service without worrying about caring for Petitioner or Petitioner having an outburst. Petitioner's parents also use respite for occasional date-nights and vacations throughout the year. This appears to be consistent with policy. However, the amount of respite authorized was clearly too much given that Petitioner had 152 hours of respite that went unused in 2023. 152 hours represents almost three full months of allotted respite at 53.5 hours per month that was not utilized. Further, Petitioner's use of respite in January and February was not consistent with policy as the family was using respite almost every day. And, while Petitioner's parents may have had a reason for using respite in that manner, i.e., Petitioner's surgery and recovery, the usage was still contrary to policy. This, plus the unutilized respite from 2023 supports CMH's decision.

However, it does appear that Petitioner's circumstances have changed since the action was taken as Petitioner's AHH has been reduced and Petitioner is sleeping less per night. As indicated at the hearing, Petitioner's mother should make sure her case manager is aware of these changes and consider putting in a request for an increase in respite if necessary due to these changes.

Based on the evidence presented, the CMH's decision was proper and should be upheld. If respite has not already been reduced, CMH should step-down the reduction over three months as proposed following the internal appeal.

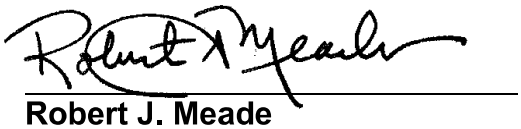
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner's request for 53.5 hours of respite per week.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

If respite has not already been reduced, CMH should step-down the reduction over three months as proposed following the internal appeal.



RM/sj

Robert J. Meade
Administrative Law Judge

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

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 23rd day of April 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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