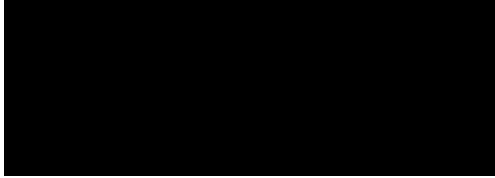




GRETCHEN WHITMER
GOVERNOR

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

MARLON BROWN
DIRECTOR



Date Mailed: July 1, 2024
MOAHR Docket No.: 24-004064
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 a request for hearing.

After due notice, a telephone hearing was held on June 11, 2024. Mira Edmonds, an attorney with the University of Michigan Law School's Pediatric Advocacy Clinic, appeared on behalf of Petitioner [REDACTED] (Petitioner). April Higgins, Provider Network Manager and Fair Hearings Officer, appeared on behalf of the Respondent Community Mental Health for Central Michigan (Respondent).

During the hearing, the following exhibits were admitted into the record:

Petitioner's Exhibits:

Exhibit A: Letter from Dr. Steven Leber, MD, PhD
Exhibit B: Care Logs from December 2, 2023, to December 8, 2023
Exhibit C: Care Logs from April 6, 2024, to April 12, 2024¹

Respondent's Exhibit:

Exhibit #1: Hearing Summary and Evidence Packet

The following witnesses testified during the hearing:

Petitioner's Witness:

[REDACTED] Petitioner's Mother

¹ Petitioner also submitted a Pre-Hearing Brief.

Respondent's Witness:

Angela Zywicki, Utilization Manager, Respondent

ISSUES

Did Respondent properly (1) reduce Petitioner's Community Living Supports (CLS) and (2) deny his 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 sixteen (16) year-old Medicaid beneficiary who has been diagnosed with, among other conditions, epilepsy; developmental delays; dysphagia; visual impairment; mitochondrial metabolism disorder; and generalized muscle weakness. (Exhibit A, page 1; Exhibit #1, pages 54, 66).
2. He is totally dependent on others for all his activities of daily living, including tube feedings, oral feedings, and diaper changes; and he needs to be monitored for seizure activity. (Exhibit A, page 1; Exhibit #1, pages 57, 64-65, 71; Testimony of Petitioner's Mother).
3. He requires around-the-clock supports, and he cannot be left alone, even when sleeping at home. (Exhibit #1, page 66; Testimony of Utilization Manager).
4. At night, Petitioner's parents must monitor him for seizures, coughing, a need for diaper changes, and any other issues. (Testimony of Petitioner's Mother).
5. His required equipment includes a wheelchair, Hoyer lift, stander, gait trainer, shower chair, toileting chair, hygiene station, hospital bed, and floor mat. (Exhibit #1, page 71).
6. Petitioner lives with his parents and two younger sisters (Exhibit #1, page 57).
7. Both parents work full-time, averaging 60-70 hours of work per week. (Testimony of Petitioner's Mother).
8. Petitioner also attends school 3 days a week, 18 hours per week in total. (Exhibit #1, page 66; Testimony of Petitioner's Mother; Testimony of Utilization Manager).
9. Since 2013, Petitioner has been approved for services through Respondent pursuant to the Habilitative Supports Waiver (HSW), with services including targeted case management, CLS, and respite care services. (Exhibit #1, pages 61, 72; Testimony of Petitioner's Mother; Testimony of Utilization Manager).

10. Petitioner has utilized his approved services within the approved ranges. (Exhibit #1, page 37).
11. As of December 1, 2023, Petitioner was approved for 70 hours per week of CLS and 18 hours per month of respite care services. (Exhibit #1, page 37; Testimony of Petitioner's Mother; Testimony of Utilization Manager).
12. Petitioner's parents were and are responsible for all hours where Petitioner is not in school or not receiving services through Respondent. (Testimony of Petitioner's Mother; Testimony of Utilization Manager).
13. He is now physically larger than his mother. (Exhibit #1, page 66).
14. For the period of December 20, 2023, through March 15, 2024, Petitioner's parents and his younger sisters were out of the country. (Testimony of Utilization Manager)
15. Petitioner could not go with them due to his care needs, and his parents arranged for a temporary guardian. (Exhibit #1, page 56; Testimony of Petitioner's Mother).
16. Prior to the trip, Petitioner requested and was approved, for an increase in his CLS services. (Exhibit #1, page 37; Testimony of Utilization Manager).
17. Specifically, Petitioner's CLS was increased from 70 hours per week to 77.25 hours per week through March 15, 2024. (Exhibit #1, page 37; Testimony of Utilization Manager).
18. Respondent also terminated Petitioner's respite care services as of December 20, 2023. (Testimony of Utilization Manager).
19. On February 12, 2024, Person-Centered Plan (PCP) Meeting was held with respect to Petitioner's PCP for the period of February 27, 2024, to February 11, 2025. (Exhibit #1, pages 70-82).
20. In the PCP that was developed, Petitioner has three identified goals: (1) to improve his mobility, be healthy, and be as independent as possible; (2) for his thumbs to be healthy, with Petitioner having a long history of chewing on his thumbs; and (3) to increase his community inclusion. (Exhibit #1, pages 70-82).
21. In support of those goals, Petitioner was to be approved for CLS and respite care services. (Exhibit #1, pages 70-82).
22. Following the PCP meeting and the development of the proposed PCP, Petitioner's Case Manager submitted requests for services to Respondent, including CLS and respite care services. (Exhibit #1, pages 78-79).

23. With respect to respite care services, Petitioner requested reauthorization of 18 hours per month. (Exhibit #1, pages 30, 79).
24. With respect to CLS, Petitioner first requested that the CLS stay at its current amount through March 15, 2024, as planned. while his parents were out of the country. (Exhibit #1, pages 78-79).
25. Petitioner also requested that, upon his parents' return, there be a temporary increase of CLS to 80 hours per week for the period of March 16, 2024 to March 24, 2024, when Petitioner was on spring break from school. (Exhibit #1, pages 37, 78).
26. Petitioner further requested that, for the rest of the plan period, *i.e.*, through February 11, 2025, that he be reapproved for 70 hours per week of CLS, which was the amount he had been approved for prior to his parents' trip. (Exhibit #1, pages 78-79; Testimony of Petitioner's Mother; Testimony of Utilization Manager).
27. Respondent reviewed all of Petitioner's requests. (Exhibit #1, pages 36-37).
28. Petitioner's mother was not contacted as part of that review. (Testimony of Utilization Manager).
29. During that review, Petitioner's Case Manager at Respondent was asked to provide Petitioner's parents' work schedule, but the Case Manager did not provide one and Respondent utilized a 40 hour per week work schedule for both parents. (Exhibit #1, page 37; Testimony of Utilization Manager).
30. Respondent also questioned the Case Manager about the supports schedule she identified and how it appeared to identify more hours in a week than what exists, and the Case Manager indicated that she had entered the hours per week that Petitioner is sleeping as both natural supports, as Petitioner's parents were his caregivers when he is sleeping, and as sleeping hours, which lead to an error. (Exhibit #1, pages 36-37).
31. The Case Manager also reported that Petitioner sleeps 59.5 hours per week (8.5 hours per night) and is in school 18 hours per week. (Exhibit #1, page 37).
32. Respondent then determined that respite care services would be denied, but CLS would be approved in part. (Exhibit #1, pages 36-37; Testimony of Utilization Manager).
33. Specifically, Respondent decided to approve 65 hours per week of CLS, with the actual authorizations made in monthly amounts to allow greater flexibility and Petitioner's natural supports responsible for any non-school, non-paid care periods. (Exhibit #1, page 37; Testimony of Utilization Manager).

34. On February 22, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that the request for additional CLS during Petitioner's spring break, i.e., March 22, 2024, to March 29, 2024, had been denied. (Exhibit #1, pages 5-11).

35. Petitioner did not appeal that decision and it is not at issue in this case.

36. That same day, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that his CLS services would be reduced as of March 16, 2024. (Exhibit #1, pages 12-17).

37. With respect to the reason for the reduction, the notice stated in part:

CLS increase was approved 12/20/23-3/15/24 while parents were out of the country. CLS hours will be reduced 3/16/24 based on medical necessity as parents will return from trip and will provide care to consumer as natural supports. Medical necessity determination was made using documentation in the chart, Medicaid Provider Manual and Michigan Mental Health Code.

* * *

The clinical documentation provided does not establish medical necessity.

CLS increase was approved 12/20/23-3/15/24 while parents were out of the country. CLS hours will be reduced 3/16/24 based on medical necessity as parents will return from trip and will provide care to consumer as natural supports. Medical necessity determination was made using documentation in the chart, Medicaid Provider Manual and Michigan Mental Health Code.

Exhibit #1, page 12

38. The potential availability of Home Help Services (HHS) for Petitioner through the Michigan Department of Health and Human Services (MDHHS) was not a factor in Respondent's decision to reduce Petitioner's CLS. (Exhibit #1, page 36; Testimony of Utilization Manager).

39. On March 18, 2024, Petitioner filed an Internal Appeal with Respondent with respect to the decision to reduce his CLS services. (Exhibit #1, page 18).

40. On March 22, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that his request for respite care services had been denied. (Exhibit #1, pages 24-29).

41. With respect to the reason for that denial, the notice stated in part:

Respite is not medically necessary as CLS is the more appropriate service.

* * *

The clinical documentation provided does not establish medical necessity.

Exhibit #1, page 24

42. On April 1, 2024, Petitioner filed an Internal Appeal with Respondent with respect to the decision to deny respite care services. (Exhibit #1, page 29).

43. On April 10, 2024, Respondent sent Petitioner a Notice of Appeal Denial stating that the Internal Appeal regarding the reduction in his CLS services had been denied. (Exhibit #1, pages 18-23).

44. With respect to the reason for that decision, the notice stated in part:

Per the Medicaid manual Community Living Supports (CLS) services may not supplant Department of Health and Human Services (DHHS) Home Help, school services and support. The request was found not to be medically necessary due to only 25 hours per week of [REDACTED] care being unaccounted for from school supports, CLS and sleeping hours. [REDACTED] is a minor child therefore some responsibility for caregiving falls to the parent/guardian.

[Petitioner's] current schedule includes on average-
School 18 hours per week

Sleeps 59.5 hours per week (8.5hrs per night)

Community Living Supports (CLS) 65 hours per week.

Out of his 90 hours per week of awake time that leaves 25 hours per week of parenting time.

It is recommended to explore DHHS home help as [REDACTED] would possibly qualify for hours. Per the Medicaid manual home help can provide (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). This could be an appropriate supplement to the 65 hours per week of CLS.

If DHHS denies home help request for 15 more hours of CLS could be revisited. Information on the Home Help Program and how to apply be found at-
<https://www.michigan.gov/mdhh>

Exhibit #1, page 18

45. That same day, Respondent also sent Petitioner a Notice of Appeal Denial stating that the Internal Appeal regarding respite care services had been denied. (Exhibit #1, pages 30-35).

46. With respect to the reason for that decision, the notice stated in part:

The Michigan Department of Health and Human Services (DHHS) website indicates that respite is not 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. [REDACTED] benefits from the Community Living Supports (CLS) that are in place. It is recommended that if additional support is felt needed, the DHHS home help services should be considered/reviewed to see if that would assist in a more appropriate and functional way than respite care.

Exhibit #1, page 30

47. On April 18, 2024, MOAHR received the request for hearing filed in this matter with respect to the reduction in Petitioner's CLS services and the denial of respite care services.

48. While this administrative hearing has been pending, Petitioner has been approved for 70 hours per week of CLS. (Exhibit #1, page 40; Testimony of Petitioner's Mother; Testimony of Utilization Manager).

49. That is what Petitioner was approved for before his parents' trip and what he is seeking now. (Testimony of Petitioner's Mother).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance

to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

42 USC 1396n(b)

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, this case concerns Community Living Supports (CLS) and respite care services through the Michigan's Habilitation Supports Waiver (HSW).

With respect to the HSW in general, and CLS and respite care services specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

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 covered state plan 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 their 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 PIHP's 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, does not

receive at least one HSW habilitative service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and 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.

* * *

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
- Meal preparation;
- Laundry;
- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);

- Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
- Shopping for food and other necessities of daily living.
- Assisting, supporting and/or training the beneficiary with:
- Money management;
- Non-medical care (not requiring nurse or physician intervention);
- Socialization and relationship building;
- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
- Leisure choice and participation in regular community activities;
- Attendance at medical appointments; and
- Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do

not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

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) is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

*MPM, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 123-125, 139-140*

Moreover, while CLS and 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, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15*

Here, as discussed above, Respondent has decided to both reduce Petitioner's CLS and deny his request for reauthorization of respite care services.

In appealing those actions, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred.

Given the record and applicable policies in this case, and for the reasons discussed below, the undersigned Administrative Law Judge finds that Petitioner has met his burden of proof with respect to both of Respondent's actions and that its decisions on CLS and respite care services must therefore be reversed.

As a preliminary matter, the undersigned Administrative Law Judge would note that, while Petitioner's Pre-Hearing Brief argued that Petitioner was previously receiving, and again wanted, 80 hours per week of CLS, it was confirmed during the hearing that Petitioner was authorized for 70 hours per week prior to the temporary increase while his parents were out of the country and that Petitioner was only seeking that amount of services going forward, with Respondent seeking to reduce his CLS to 65 hours per week.

With respect to that dispute, Petitioner first argues that Petitioner cannot be compelled to apply for Home Help Services (HHS) through the Michigan Department of Health and Human Services (MDHHS) as a requirement for receiving HHS.

However, that argument is incorrect as the MPM expressly provides that if, like Petitioner, a beneficiary living in unlicensed homes needs assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping, then the "the beneficiary must request Home Help from MDHHS". *MPM, January 1, 2024 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 125 (Underline added for emphasis)*.

Nevertheless, while Petitioner is required to apply for HHS under the applicable policy and the notices of action alluded to such potential services, Respondent's Utilization Manager expressly testified that the potential availability of HHS was not a factor in Respondent's decision to reduce Petitioner's CLS, and the undersigned Administrative Law Judge will therefore not consider it either.²

Similarly, Petitioner's argument that Respondent's decision must be reversed because Respondent would be improperly compelling Petitioner's parents to be natural supports should also be rejected.

In support of that argument, Petitioner correctly notes that the MPM provides that, while the use of natural supports is encouraged to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing, Respondent "may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services." *MPM, January 1, 2024 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 2*.

² If Petitioner does apply for HHS, CLS may be authorized for the activities typically covered by HHS while he awaits a decision from MDHHS or while any appeal of a negative decision is pending. See *MPM, January 1, 2024 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, pages 124-125*.

However, while there is a dispute about the scope and duration of supports Petitioner's parents can and do provide, no one disputes that they do provide natural supports, Respondent has continually approved services, and the record does not reflect that Respondent has ever required assistance as a condition on Petitioner's receipt of services through it. Moreover, Petitioner is a minor and the HSW itself notes the existence of legally responsible individuals, such as the parents of a minor child, in the provision of personal care or similar services. See *Approved HSW Application, Appendix C: Participant Services, C-2: General Service Specifications (3 of 3), d.* Similarly, albeit with respect to CLS and respite through the State Plan, the MPM provides 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." *MPM, January 1, 2024 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 149.*

Nevertheless, in reviewing the record in this case regarding CLS, including Petitioner's natural supports, the undersigned Administrative Law Judge finds that Respondent erred in deciding to reduce Petitioner's CLS and its decision to do so must be reversed.

Petitioner was previously approved for 70 hours per week of CLS prior to the temporary increase while his parents were out of the country and, while that previous approval is not dispositive, it does weigh in favor of a finding that such hours were needed given that Respondent did not identify any change or improvement in Petitioner's needs or circumstances that would warrant fewer hours. At most, Respondent alluded to red flags in the past provision of services prior to Petitioner's parents' trip, but no documentation was provided regarding any issues and Respondent apparently did not find them sufficient to reduce Petitioner's services before. Moreover, while Respondent did provide and cite to some Care Logs completed while Petitioner's parents were away, the undersigned Administrative Law Judge agrees with Petitioner's argument that such logs have limited probative value to calculating Petitioner's CLS while his parents are home.

Moreover, in reviewing Petitioner's available natural supports, Respondent found that, even with a reduced amount of CLS, Petitioner's parents would only be providing 25 hours per week of natural supports and that finding is unsupported by the record. While Respondent based its determination of natural supports on Petitioner's waking hours, it is undisputed that Petitioner's parents are responsible for his care for *all* hours when he is not in school or receiving paid supports, and that amount of time includes hours at night and exceeds 25 hours per week. Petitioner is an atypical sixteen-year-old who cannot be left alone at any time, even while sleeping, and his mother credibly testified regarding necessary care provided at night if Petitioner is having a seizure, coughing, or needs a diaper changed. And, while the record does not reflect how often such care occurs, it exists and should be considered in calculating Petitioner's services.

Similarly, while Petitioner was not receiving respite care services at the time his request for the reauthorization of such services was denied, the undersigned Administrative Law Judge likewise finds that Respondent erred in that decision.

Petitioner has previously been authorized for 18 months of respite care services; the serviced ended because his parents were out of the country and not providing any natural supports, as opposed to any finding of a lack of medical necessity for them; and there was no change or improvement in Petitioner's needs or circumstances that would suggest that respite care should not have been reauthorized upon their return, especially given that Petitioner is only getting bigger and more difficult to care for.

Moreover, the record further reflects that Petitioner's parents provide significant natural supports; that the care demands of their unpaid care causes daily stress; and that Respondent erred by miscalculating the amount of such supports when assessing Petitioner's request for respite care services.


DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Respondent's decisions are **REVERSED**, and it must initiate a reassessment of Petitioner's services.

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

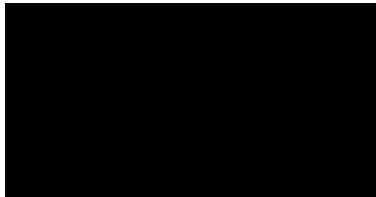
I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 1st day of July 2024.

S. James

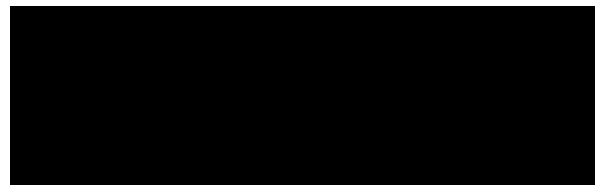
S. James
**Michigan Office of Administrative
Hearings and Rules**

Via Electronic Mail:

Petitioner



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