STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

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

MARLON BROWN
DIRECTOR

[redacted]

Date Mailed: July 3, 2024
MOAHR Docket No.: 24-005212
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 July 2, 2024. [redacted] Petitioner's mother and guardian, appeared and testified on Petitioner's behalf. [redacted] Petitioner, appeared as a witness.

Attorney Evan George, Fair Hearing Officer, appeared on behalf of Respondent, Washtenaw County Community Mental Health. (Respondent or CMH.) Ebony Montgomery, Program Administrator, appeared as a witness for Respondent.

ISSUE

Did the CMH properly deny Petitioner's request for 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 his mother. (Exhibit C, p 1; Testimony.)

4. Petitioner is diagnosed with unspecified schizophrenia spectrum and other psychotic disorder. (Exhibit 1, p 12; Testimony.)

5. On October 13, 2023, Petitioner's mother/guardian requested respite services for a month-long period in early 2024 when she would be out of the country. (Exhibit 1, pp 38-39; Testimony.) Specifically, the request indicated, "Mom is the guardian for consumer who will be out of the country for one month. There are no other family members who are able to rely on that will be able to assist this consumer and make sure that this consumer takes medication, attends medication review and injection appointments." (Exhibit 1, p 38; Testimony.)

6. When contacted by CMH staff regarding the request for respite, Petitioner's mother/guardian indicated that Petitioner may not let staff in when she is gone because he does not want any help at all, that Petitioner has been doing everything on his own, and that the respite was being requested only on an as-needed basis as a back-up to Petitioner's other services. (Exhibit D, p 4; Testimony.)

7. A Respite Assessment completed by Petitioner's case manager on November 14, 2023, determined that Petitioner was independent with all the skills listed on the assessment. (Exhibit 1, pp 10-12; Testimony.)

8. On December 11, 2023, CMH sent Petitioner an Adverse Benefit Determination indicating that respite care services were denied. (Exhibit B, pp 1-7; Testimony.) Specifically, the notice indicated, in relevant part:

> There does not appear to be a need presented at this time for respite services during the Jan/Feb 2024 period being requested. If the consumer's needs change, the treatment will re-assess. If immediate health and safety concerns develop the CMH treatment team (potentially in collaboration with the 24/7 crisis team) will provide support. Also the consumer's willingness to participate in respite services will also be necessary unless the consumer's rights are limited/restricted through the Behavioral Treatment Committee.
>
> (Exhibit B, p 1.)

9. On December 20, 2023, Petitioner filed a request for a local appeal. (Exhibit 1, p 7; Testimony.)

10. On January 4, 2024, following the internal appeal, CMH sent Petitioner a Notice of Appeal Denial, which upheld the original denial of respite. (Exhibit 1, pp 7-8; Testimony.) Specifically, the notice indicated in relevant part:

> Your Internal Appeal was denied for the service/item listed above because:
>
> Due to the uncertainty around whether the requested services will be utilized in the event they are authorized, the Committee concluded the decision to deny your request must be upheld. The Committee carefully considered the following:
>
> - Your written local appeal request and Adverse Benefit Determination dated 12/11/2023;
> - Respite Request form (provided to you in hard copy at the conclusion of your appeal);
> - Respite scoring sheet (also provided to you in hard copy at the conclusion of your appeal);
> - Your verbal statement provided at the appeal;
> - The statements of WCCMH Program Administrator Ebony Montgomery at the appeal;
> - Progress Note dated 12/7/2023 (enclosed);
> - PIHP policies on Utilization Management and Consent to Services (enclosed)
>
> In reviewing this information, the Committee noted the following:
>
> Upon processing the request when it was first received, the clinical team's understanding was that the requested services would be utilized within the specified time frame. The information in the Respite request form was gathered under this assumption that the need for respite services was certain to arise and the services would commence at that time.
>
> Per PIHP policy, authorizing and commencing a new service requires updating the Individual Plan of Service (IPOS) and obtaining the consent of the individual-served or Guardian to commence the service. In the process of updating the IPOS

goals to define the amount, scope, and duration of the requested services, it was reported to the clinical team that the services would be utilized only if and when you or your Guardian indicates that the need arises. As a result, the CMH does not have consent to begin the services or clinical information indicating an existing need for them. It has been reported you are currently doing well, though there is a history of the need for support arising when your Guardian leaves town as will occur later this month.

Other equally (or possibly more) efficacious services were offered instead of Respite to meet any needs that may arise during that timeframe. Increasing the frequency of visits with Case Management and/or contact with the Crisis Team for wellness support were declined by your Guardian. Instead this request for Respite services on an if-needed and as-needed basis is being pursued. The alternatives to Respite offered would be provided by trained and credentialed behavioral health professionals and would be less restrictive. The alternatives to Respite can be administered over the phone or virtually whereas Respite must be provided face to face by providers with less training.

Your Guardian also expressed concern over whether you would willingly engage with a service provider with whom you have no familiarity/experience. Your Guardian intends to introduce you to a Respite provider who will agree to fulfill the service need if and when it arises. The Clinical team is offering to have professionals with prior experience with you available to provide support if and when the need arises.

Since an actual need for the requested Respite services has yet to arise, and since these equally efficacious alternatives were declined, the Clinical team determined the "documentation provided does not establish medical necessity" for Respite services. In order to update the IPOS goals and enter authorizations for new services, the need for the services must be current and the expectation must be that the services will be provided. The Local Dispute Resolution Committee agrees with the Clinical Teams reasoning in this decision and therefore concludes this determination must be upheld.

The Committee highly recommends you meet again with your clinical team as soon as possible to create a plan to ensure that your needs are met in the coming months. Such

> a plan may include some combination of the alternatives discussed above.
>
> You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider requested coverage on your behalf, we have sent a copy of this decision to your provider.
>
> (Exhibit 1, pp 7-8.)

11. On May 9, 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 respite services were not appropriate in these circumstances because there was not an existing need for the services and other equally efficacious, less restrictive services could meet Petitioner's needs during the timeframe in question. CMH noted that in order to update the IPOS goals and enter an authorization for a new service (respite), there must be a current need for the service and an expectation that the service will be provided. CMH argued that Petitioner's needs could be met by other more efficacious, less restrictive services, such as increasing the frequency of visits with the Case Manager and/or contact with the Crisis Team.

Petitioner's mother/guardian argued that mental illness (MI) respite services should not be treated differently from developmental disability (DD) respite services, where a block of respite hours can be authorized for the IPOS period and the family can determine with the provider when and how those hours are used. Petitioner's mother indicated that since she was not able to get respite in place prior to her trip, she had to arrange to get Petitioner an expedited passport so that he could accompany her. Petitioner's mother argued that Petitioner would likely not engage with the Crisis Team as he would not be familiar with them. Petitioner's mother indicated that she attends all Petitioner's appointments with him and was concerned that Petitioner might not attend on his own in her absence.

Petitioner bears the burden of proving by a preponderance of the evidence that respite services were medically necessary as requested. Based on the evidence presented, Petitioner has failed to prove by a preponderance of the evidence that the respite services were medically necessary.

As indicated above, "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." In other words, respite is designed to give a beneficiary's family a break from caregiving. Here, however, it did not appear at the time the request was made that Petitioner was receiving any regular, ongoing, caregiving from his family. Petitioner's mother/guardian informed CMH staff that Petitioner had been doing everything on his own, and that the respite was being requested only to be used on a potentially as-needed basis. In such an instance, it would therefore be inappropriate to authorize respite because there would be no regular, ongoing, caregiving to give the family a break from.

In further support of this determination, a respite assessment completed by Petitioner's case manager on November 14, 2023, found that Petitioner was independent with all skills listed on the assessment. Again, someone who is independent with all his daily skills would not be receiving regular, ongoing, caregiving from which a break would be needed.

Further, CMH must deny services "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." Here, CMH offered to increase the frequency of Petitioner's case management visits and/or rely on CMH's crisis team to intervene if needed when Petitioner's mother/guardian was out of the country. Both of these interventions, which can be done remotely, would be less restrictive than an in-person respite service, especially when it is not known any services would actually be needed.

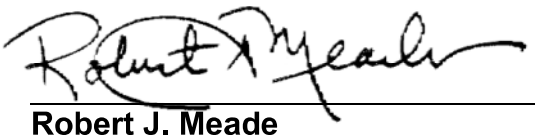
Based on the evidence presented, the CMH's decision was proper and should be upheld.

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 respite services.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



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 3rd day of July 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

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