



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

[REDACTED]
MI [REDACTED]

Date Mailed: December 18, 2024
MOAHR Docket No.: 24-012113
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon a request for a hearing filed on the minor Petitioner's behalf.

After due notice, a telephone hearing was held on December 11, 2024. [REDACTED] Petitioner's Mother, appeared on behalf of Petitioner. Madeline Prusinowski, Autism Supports Coordinator, appeared as a witness for Petitioner. Stacy Coleman appeared on behalf of the Respondent, Macomb County Community Mental Health (Department).

Exhibits:

Petitioner	1 – Request for Hearing
Department	A – Hearing Summary

ISSUE

Did Department properly deny Petitioner's request for Respite 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 Medicaid beneficiary, receiving services through Department. (Testimony.)
2. Department is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the Department service area.

3. As of July 3, 2024, Petitioner was approved for 22.5 hours a week of direct therapy that included occupational therapy, speech language services, applied behavioral analysis and targeted case management. (Testimony; Exhibit A.)
4. In the Fall of 2024, Petitioner was to begin school on a full-time academic schedule. (Testimony.)
5. On or around July 3, 2024, Petitioner requested 15 hours per month of respite services. (Exhibit A; Testimony.)
6. At the time of the request, Petitioner's mother was employed nearly full-time and attended online classes one day week. Additionally, Petitioner's mother received 5 hours of informal support from her mother 4 days a week. (Exhibit A; Testimony.)
7. On July 3, 2024, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's request was denied. The notice stated specifically:

Your clinician requested a continuation of 15 hours per month of respite services for the date range 7/8/2024-12/31/2024. After a comprehensive review of consumers medical chart and in conjunction with the Medicaid Provider Manual it was determined that documentation does not appear to support medical necessity of respite services at this time. Request for respite services in the amount of 60 units per month has been denied.¹

8. Shortly after the denial, Petitioner became unemployed and has remained unemployed up through the date of the hearing. (Testimony.)
9. On or prior to August 6, 2024, Petitioner submitted to Department, a request for internal appeal. (Exhibit A.)
10. On August 6, 2024, the Department sent Petitioner a Notice of Appeal Denial. The notice upheld the previous denial and provided the following:

You are appealing the denial of 15 hours per month 7/8/2024-12/31/2024. A review of the record occurred. [REDACTED] is a young child who needs someone to watch him for his health and safety, no matter his disability. There is no proof that he needs trained staff for breaks in care. The requested respite services are more than he needs. He can keep getting better with the services he already has, and the family can use natural caregivers or paid help to give them breaks from caregiving. According to the Medicaid

¹ Exhibit A, p 9.

Provider Manual, medical necessity is not met for these services as requested and the denial is upheld.²

11. On November 4, 2024, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit A.)

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.³

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.⁴

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

² Exhibit A, p 3.

³ 42 CFR 430.0.

⁴ 42 CFR 430.10.

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...⁵

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

Here, as discussed above, Petitioner is requesting Respite services through Department. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

17.4.G. 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.

⁵ 42 USC 1396n(b).

- "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 (revised per bulletin MMP 22-36) their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family

- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.⁶

Additionally, whether through self-determination or traditional arrangements, any service authorized through Department must be medically necessary. Regarding the required 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

⁶ MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2023, pp 147-149, 155-156.

- 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.⁷

Here, as discussed above, Petitioner is requesting Respite. In order to prevail in their request, the Petitioner must show the requested services are medically necessary. After reviewing the evidence presented, however, Petitioner has failed to present any evidence to support their request.

Petitioner's arguments focused on the Petitioner's behaviors and further argued the lack of services being provided. Petitioner, however, could not provide any evidence to corroborate their claims regarding the services not being provided and further could not identify behaviors that necessitated the need for respite services in light of the fact of Petitioner's mother being at home and having an amazing informal support in her own mother.

Consequently, I find the Department properly denied Petitioner's request for additional Medicaid benefits as the Petitioner has failed to show the request as being medically necessary.

⁷ MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2023, pp 13-15.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly denied Petitioner's request for additional Medicaid services.

IT IS THEREFORE ORDERED that:

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

CA/pe



Corey Arendt
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

Via Electronic Mail:

DHHS Department Contacts

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