Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: May 2, 2025
Docket No.: 25-009838
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.
هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.
এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।
Este es un documento legal importante. Por favor, que alguien traduzca el documento.
这是一份重要的法律文件，请让别人翻译文件。
Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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 prehearing conference was held on April 16, 2025, followed by a status conference on April 30, 2025. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf.

Gina Fortino, Supervisor, Utilization Management and Tresa Bolger-Dunlap, Deputy Director of Habilitative Services, appeared and testified on behalf of Respondent, Shiawassee Health & Wellness (Respondent or CMH).

Petitioner's request for hearing was admitted as Exhibit 1, pp 1-8.

ISSUE

Did the CMH properly deny Petitioner's request for continued respite and fiscal intermediary services based on Petitioner's Medicaid coverage of Flint-Water?

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 respite and fiscal intermediary services through CMH. (Exhibit 4, p 1.)

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. (*Id*.)

3. In February 2025, Petitioner submitted a request to continue respite and fiscal intermediary services. (*Id*.)

4. On February 26, 2025, CMH sent Petitioner an Adverse Benefit Determination indicating that the request for continued respite and fiscal intermediary services was denied. (Exhibit 1, pp 4-8.) Specifically, the notice indicated, in relevant part:

> Due to Luke's Medicaid being noted as "Flint-Water", he has limited Medicaid coverage which includes Case Management and follow up until the age of 21. You can see the coverage L below reflects the "Limited" status. The status must be "full" for enrollment into the 1915i(SPA) for Respite services.
>
> This is from the State of Michigan and it means that Respite services and Fiscal Intermediary (Stuart Wilson) is not a service we are allowed to provide with his current type of Medicaid coverage.
>
> (Exhibit 1, p 4.)

5. On March 17, 2025, 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:

> **SECTION 6 - FLINT FAMILY SUPPORTS COORDINATION SERVICES**
>
> Family Supports Coordination services are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system who meet the Medicaid eligibility requirements.

Family Supports Coordination services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. Family Supports Coordination services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities.

In addition to Family Supports Coordination services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children up to age 21, Non-Emergency Medical Transportation (NEMT),and Maternal Infant Health Program (MIHP) services.

Medicaid Provider Manual
Special Programs Chapter
January 1, 2025, pp 13-15
Emphasis added

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, 2025, pp 149-150, 157-159
Emphasis added.

CMH's representatives confirmed that it was their understanding that Flint-Water was full Medicaid coverage and Petitioner should not have been denied these services.

Petitioner's mother indicated that Petitioner has been receiving respite and fiscal intermediary for some time and his Medicaid coverage has not changed.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH improperly denied his request for respite and fiscal intermediary services. Based on the evidence presented, Petitioner has met that burden.

As the above policy indicates, coverage under the Flint-Water program entitles beneficiaries to, "the full array of Medicaid-covered benefits." Between the prehearing conference and the status conference, this administrative law judge also confirmed that "Flint-Water" is full Medicaid coverage. Respite and fiscal intermediary services are Medicaid covered benefits. As such, CMH's denial of such services due to Petitioner's Medicaid coverage was improper and must be overturned.

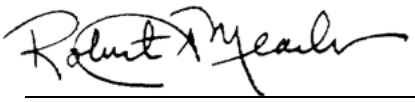
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly denied Petitioner's respite and fiscal intermediary services.

IT IS THEREFORE ORDERED that:

The CMH decision is **REVERSED**.

Within 10 days of the receipt of this Order, Respondent should certify to MOAHR that it has taken action consistent with this decision by approving Petitioner's continued authorization for respite and fiscal intermediary services.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

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