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

Date Mailed: August 14, 2025
Docket No.: 25-025308
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

This is an important legal document. Please have someone translate the document.

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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Case No.: [redacted]
Petitioner: [redacted]

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 August 13, 2025. [redacted] Petitioner's mother and guardian, appeared and testified on Petitioner's behalf.

Susan Richards, Director of Quality Improvement, Compliance and Customer Services, appeared and testified on behalf of Respondent, The Right Door. (Respondent or CMH.) Melanie Zalis, Case Manager; Melissa Peterson, Case Manager Supervisor; and Kerry Possehn, CEO appeared as witnesses for Respondent.

ISSUE

Did the CMH properly authorize Petitioner's respite hours?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. 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)

2. Petitioner receives Medicaid-covered behavioral health services through The Right Door. Her services are authorized based on a comprehensive biopsychosocial assessment, respite assessments, person-centered plan (PCP) goals, and the Michigan Medicaid Manual criteria for respite services. (Exhibits F, A, G, H; Testimony).

3. At her annual reassessment, Petitioner and her guardian completed a respite assessment. (Exhibit A; Testimony).

4. On April 29, 2025, Respondent's CLS/Respite Committee met and approved a reduction in respite hours based on the assessment results and available alternative supports. (Exhibit B; Testimony). Specifically, Petitioner's respite hours were reduced from 17.5 hours per week to 8 hours per week. (*Id*; Testimony).

Petitioner also receives 2 hours of Adult Home Help per day. (*Id*; Testimony).

5. On April 29, 2025, a Letter of Adverse Benefit Determination was mailed to Petitioner's guardian, with an effective date of May 10, 2025. (Exhibit C; Testimony).

6. Petitioner's guardian filed a local appeal the same day (Exhibit D). The appeal was reviewed by an independent clinical supervisor not involved in Petitioner's services. (*Id*; Testimony).

7. On May 21, 2025, this clinician upheld the reduction, citing the validity of the assessment tool, approval by all involved parties, and the availability of other supports, including Community Living Supports (CLS) and the Listening Ear Activities (LEA) program. (Exhibit D; Testimony).

8. On July 11, 2025, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1).[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.

[1] Petitioner's guardian originally tried to fax the documents on May 28, 2025, but there was a problem with the transmission and they were not received by MOAHR.

> 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
April 1, 2025, 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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17.4.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.

- "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
April 1, 2025, pp 150-151, 158-160
Emphasis added.

CMH argued that it properly reduced Petitioner's respite after a comprehensive review. CMH pointed out that MPM § 17.4.G requires respite hours to be based on medical necessity and according to MPM § 2.5.D, PIHPs may determine the amount, scope, and duration of services using standardized tools and committee review, provided the process considers the individual's needs. CMH argued that after review, Petitioner's assessed needs supported 8 hours per week of respite. CMH noted that additional caregiver support is available through CLS, LEA, and daily Home Help. CMH also noted that the reduction was reviewed by qualified staff and upheld on appeal after independent clinical review.

Petitioner's guardian argued that the reduction in respite hours will place an increased burden on the family, particularly given Petitioner's ongoing needs. She expressed concern that alternative services such as CLS and the LEA program do not offer the same type of caregiver relief as in-home respite. Petitioner's guardian argued that the prior level of respite more accurately reflected Petitioner's needs and the family's caregiving demands.

Petitioner's guardian also questioned whether the assessment tool fully captured Petitioner's behavioral and supervision requirements, and whether the process gave adequate weight to the guardian's input about day-to-day care. Petitioner's guardian

noted that she is a single mom and there is no one else in the home to help with Petitioner's needs.

Petitioner's guardian indicated that Petitioner has a lot of appointments, including dental, doctor, gynecologist, podiatrist, rheumatologist, eye doctor, and she has to transport Petitioner to all these appointments and sit in on the appointments. Petitioner's guardian indicated that she also spends a lot of time filling out paperwork regarding Petitioner for social security and MDHHS, and has to meet with The Right Door once per month. Petitioner's guardian noted that she recently had to have a back up guardian appointed to give her assistance. Petitioner's guardian testified that when she is doing all these things there is not time to do things around the house, like chores.

Petitioner's guardian testified that Petitioner goes to a day program and the program is everything to her. Petitioner's guardian indicated that reducing Petitioner's respite hours would not be good for Petitioner or for Petitioner's guardian. Petitioner's guardian testified that Petitioner gets stress induced migraines, suffers from scoliosis, and is developmentally delayed. Petitioner's guardian noted that Petitioner has a speech problem so she is hard to understand and Petitioner does not understand a lot of what goes on around her.

Regarding using the Listening Ear program, Petitioner's guardian indicated that she saw a few of the programs did not end until 9:00 p.m. and Petitioner is usually in bed by then. Petitioner's guardian testified that she thinks going to such a program would be tiresome for Petitioner. Petitioner's guardian testified that she has tried CLS a couple times but has had terrible luck. Petitioner's guardian indicated that it is difficult to find staff locally to provide CLS because she lives in a small town. Petitioner's guardian also noted that Petitioner gets used to people in her life so changes in staff are very difficult for her.

Petitioner bears the burden of proving by a preponderance of the evidence that 17.5 respite hours per week are medically necessary. Based on the evidence presented, Petitioner has failed to prove by a preponderance of the evidence that 17.5 respite hours per week are medically necessary.

Medicaid policy allows PIHPs to use structured assessments to determine service amounts, as long as the process is individualized. Here, The Right Door applied its respite assessment tool, reviewed results through a multi-member clinical committee, and considered the guardian's input. The guardian participated in the reassessment meeting, and the record indicates her approval of the final assessment at that stage, even if she later disagreed with the outcome.

The independent appeal review reaffirmed the reduction, specifically noting the assessment's validity and the presence of other supports. While I acknowledge the guardian's concerns that CLS and LEA may not fully replace respite, the Medicaid standard is *medical necessity*, not caregiver preference. The evidence supports that

Petitioner's needs can be met with the authorized respite of 8 hours per week plus other available services.

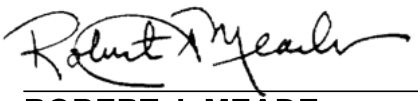
Petitioner did not present persuasive evidence that the assessment tool was applied incorrectly, that the process failed to consider her individual circumstances, or that the reduction violates Medicaid policy. As such, based on the evidence presented, the CMH's decision was proper and should be upheld.

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 continued 17.5 hours of respite per week and authorized 8 hours of respite per week.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



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

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