

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

P. O. Box 30763, Lansing, MI 48909  
(517) 373-0722; Fax (517) 373-4147

**IN THE MATTER OF:**

**MAHS Docket No. 15-017047 CMH**

██████████

██████████

██████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for hearing filed on the minor Appellant's behalf.

After due notice, a telephone hearing was held on ██████████ ██████████ Appellant's mother, appeared and testified on Appellant's behalf through the use of an interpreter. ██████████, Appellant's supports coordinator, also testified as a witness for Appellant. ██████████ Assistant Corporation Counsel, represented the Respondent ██████████ County Community Mental Health (CMH). ██████████, ██████████ Office Manager, testified as a witness for the CMH.

**ISSUE**

Did the CMH properly deny Appellant's request for additional 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. Appellant is a ██████████ year-old Medicaid beneficiary who has been diagnosed with severe mental retardation and Rubinstein-Taybi Syndrome. (Exhibit A, pages 11, 34).
2. Appellant also has substantial functional limitations in self-care; expressive and receptive language; learning; age-appropriate behaviors; and self-direction. (Exhibit A, page 18).
3. Due to developmental disability and substantial functional limitations, Appellant has been receiving support services through the CMH and its contracted provider ██████████. (Exhibit A, page 19).

██████████  
**Docket No. 15-017047 CMH**  
**Decision and Order**

4. Specifically, Appellant's services have included supports coordination, Community Living Supports (CLS), respite care services, behavioral services, and occupational therapy. (Exhibit A, page 19).
5. Appellant's respite care services were approved as two types: in-home respite and contracted/out-of-home respite. (Testimony of Supports Coordinator; Testimony of ██████████ Manager).
6. The contracted/out-of-home respite was to be provided overnight at a facility. (Testimony of ██████████ Manager).
7. On ██████████ an annual assessment of Appellant's service was conducted. (Exhibit A, pages 11-37).
8. During that assessment, it was noted that Appellant's mother was frustrated with overnight respite facility as the facility always seemed to be booked when the family needed to use it and that the language difference is also a barrier to Appellant using the facility. (Exhibit A, page 19).
9. It was further noted that Appellant's mother was requesting in-home overnight respite in order to ensure Appellant's health and safety when the family is out-of-town. (Exhibit A, page 19).
10. Appellant's supports coordinator subsequently requested █ days per year of contracted respite in the home. (Testimony of Supports Coordinator).
11. When doing so, she purposefully chose to use HCPCS Code H0045 in identifying the requested respite care services. (Testimony of Supports Coordinator).
12. HCPCS Code H0045 is for "Respite care services in out-of-home setting" and, as part of its rate, it includes the cost of room and board. (Exhibit A, page 39; Testimony of ██████████ Manager).
13. On ██████████, the CMH sent Appellant written notice that the request for "Respite Care – Overnight" in the amount of █ days per year was denied. (Exhibit A, page 5).
14. With respect to the reason for the denial, the notice provided:

Denied request for █ days per auth of Contracted Respite. Documentation not found to support the medical necessity for why the contracted Respite Home can not be used and intensity of Respite authorized is adequate in intensity to assist in

maintaining the goal of living in a natural community home by temporarily relieving the unpaid care giver from care giving.

*Exhibit A, page 5*

15. On ██████████, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf with respect to that denial. (Exhibit A, page 9).
16. In part, that request for hearing stated that Appellant's mother was "appealing the denial of [Appellant's] contracted respite (H0045) because the denial was upheld by the LDR recommendation." (Exhibit A, page 9).

### **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 statutes, 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*

Additionally, 42 CFR 430.10 states:

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 also 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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided by ██████████ pursuant to that waiver are respite care services and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states:

### **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).
- Children 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 child 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.)

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 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.**

However, while respite care is a covered service, Medicaid beneficiaries are still only entitled to medically necessary services as the waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. See 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM states:

## **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, July 1, 2015 version  
Mental Health/Substance Abuse Chapter, pages 12-14*

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as respite care services:

**SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)**

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more

goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

### **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

\* \* \*

### **17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES**

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

**Docket No. 15-017047 CMH**  
**Decision and Order**

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 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 B3 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 his/her 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. MDCH 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.

*MPM, July 1, 2015 version  
Mental Health/Substance Abuse Chapter, pages 119-120*

**Docket No. 15-017047 CMH**  
**Decision and Order**

Here, as discussed above, Appellant's supports coordinator purposefully used HCPCS Code H0045, which the parties identified as contracted respite, when requesting █ days per year of overnight respite in Appellant's home for Appellant. The CMH denied that request and Appellant filed a request for administrative hearing.

In support of the denial, the CMH's witness noted that HCPCS Code H0045 is for "Respite care services in out-of-home setting" and, as part of its rate, it includes the cost of room and board. She also noted that the above policy regarding respite care services expressly provides that the 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. She further testified that the CMH can only review the request that was submitted and that the request in this case had to be denied as approving in-home respite that includes the cost of room and board would violate policy.

In response, Appellant's mother testified regarding Appellant's needs and the difficulties they have had in using the overnight respite care facility, including difficulties related to language differences and in finding times when the facility is not full.

Appellant's supports coordinator also testified regarding the difficulties Appellant's family has had with the overnight respite care facility and how it would be better for him to receive respite in the home, where his aunt is his worker and where he is more comfortable. She further testified that she requested contracted respite because previous requests for in-home respite had all been denied and that she is aware of other people who use contracted respite in their home.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying his request.

Given the record in this case, Appellant has failed to meet that burden of proof and the CMH's decision must be affirmed. The specific request in this case was for Appellant to receive a type of respite that includes the cost of room and board while remaining in his home. However, the above policy expressly provides that the "[c]ost 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." See MPM, July 1, 2015 version, Mental Health/Substance Abuse Chapter, page 134. Accordingly, the request was properly denied.

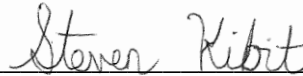
For the reasons identified by his witnesses, Appellant may be entitled to additional respite in the home. However, additional in-home respite, as opposed to what the parties identified as contracted respite, was not requested or reviewed, and that issue is therefore not before the undersigned Administrative Law Judge. To the extent Appellant wishes additional in-home respite, he can always request it and, if it is denied, file another request for hearing. With respect to the decision that is at issue here, the CMH's decision must be affirmed pursuant to the clear policy.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request for additional respite care services.

**IT IS THEREFORE ORDERED** that:

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



\_\_\_\_\_  
Steven J. Kibit  
Administrative Law Judge  
for Nick Lyon, Director  
Michigan Department of Health and Human Services

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.