[redacted]
[redacted], MI [redacted]

Date Mailed: April 21, 2020
MOAHR Docket No.: 20-001264
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 the Appellant's request for a hearing.

After due notice, a hearing was held on April 8, 2020. [redacted], Petitioner's mother, appeared on behalf of the Petitioner. Anthony Holston, Assistant Vice President of Appeals & Grievances, appeared on behalf of Respondent, Lakeshore Regional Entity (Department). Stephanie Segar, Supports Coordinator; and Sara Milnikel, CLS & Residential Coordinator, appeared as witnesses for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly determine an appropriate level of respite care services for Petitioner?

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 from the Department. (Exhibit A, p 23; Testimony).

2. Petitioner requires 24 hour supervision and has been diagnosed with hypotonic cerebral palsy, Lennox Gestalts Syndrome, blindness, chronic

constipation, chronic rhinosinusitis, chronic kidney disease, congenital hypotonia, chronic state encephalopathy, frequent UTIs, Gastrostomy tube dependent, global development delay, left hemiparesis, neuromuscular respiratory weakness, non-intractable epilepsy with complex seizures, obstructive sleep apnea, polycystic kidney disease, precocious puberty, restrictive lung disease, static encephalopathy, acid reflux and vesicoureteral reflux. (Exhibit A, p 36).

3. As of January 21, 2020, Petitioner resided with her mother and attended school. At the time, Petitioner rode the bus to and from school. (Exhibit A, pp 23, 34; Testimony).

4. Petitioner is nonverbal and will make noises when she is hungry, needs to be changed, or wants something. (Exhibit A, p 28).

5. Prior to January 14, 2020, Petitioner received from Oakland County Community Mental Health, 40 hours a week of respite services. Petitioner also received HAB Waiver benefits. (Exhibit A, p 26; Testimony).

6. On January 14, 2020, Petitioner requested 40 hours a week of respite from Respondent. (Exhibit A, p 23).

7. On January 16, 2020, Petitioner moved from Oakland County to Allegan County. (Exhibit A, p 26; Testimony).

8. On January 21, 2020, Petitioner met with Respondent for an assessment. During the assessment, Petitioner's mother indicated Petitioner was experiencing hundreds of seizures a day but was now experiencing between 20 to 50 a day. (Exhibit A, p 28).

9. On February 17, 2020, Department issued a notice of adverse benefit determination. The notice indicated Petitioner's respite request for 40 hours of respite a week was denied. The notice further indicated the Petitioner would be approved for 20 hours a week of respite. (Exhibit A, p 21).

10. On February 19, 2020, Petitioner submitted to Department an internal appeal. (Exhibit A, p 2).

11. On February 21, 2020, Department issued a notice of appeal denial. The notice indicated the following:

> The consumer was denied a request for 40 hours a week of Respite services and approved 20 hours a week of Respite services. The Michigan Medicaid Provider Manual states that respite services are provided on a short-term intermittent basis. Short term defined as: a few hours or

> days; weekends; vacations. The manual describes intermittent as services that do not occur regularly or continuously. The Michigan Medicaid Provider Manual states that a Wavier for Respite Services is not intended to be continuous or on a long-term basis or as part of daily services. The Provider Manual also notes that exceptions (Waivers) are made on an occasional basis when regular Respite services are insufficient. In this case, the request is for a continuous Waiver of Respite services for 40 hours a week. After a review of the clinical information provided and the Michigan Medicaid Manual statements regarding Respite services it is recommended that the Respite services be provided at the frequency of 20 hours a week and that the Waiver of Respite services for an additional 20 hours a week be denied as not being in accordance with Michigan Medicaid Manual guidelines. The recommendation is for the consumer to pursue additional support services such as community living supports or other services of paid support. (Exhibit A, pp 2-4).

12. Petitioner had formerly used the 40 hours a week of respite to have someone in her home to watch her while her mother slept. (Testimony).

13. At the time of the hearing, Petitioner was seeking HAB Waiver benefits and OT Therapy. (Testimony).

14. Petitioner did not qualify for Private Duty Nursing as she did not require skilled nursing interventions. (Testimony).

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.[1]
>
> 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.[2]

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…[3]

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 has been receiving respite care services through Respondent. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.3.I. RESPITE CARE SERVICES**

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[1] *42 CFR 430.0*

[2] *42 CFR 430.10*

[3] *42 USC 1396n(b)*

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.[4]

While respite care is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[5] Regarding 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
> - 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.

[4] *MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2019, pp 145-147*

[5] *See* 42 CFR 440.230.

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.[6]

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

> **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.

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2019, pp 14-15.

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 ensure 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.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the

	typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency.

	Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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:

- 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. 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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.[7]

Here, as discussed above, Department decided to allocate 20 hours a week of respite to Petitioner rather than the 40 hours a week being requested.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time it made the decision.

[7] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2019, pp 129-130.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and Department's decision must therefore be affirmed.

While it appears that nothing significant has changed with respect to Petitioner[8], Petitioner is also still authorized for a substantial amount of respite care and the authorization of respite care appears sufficient to provide Petitioner's natural supports with short-term, intermittent relief from the daily stress and care demands during times when they are providing unpaid care, especially given Petitioner's other services and circumstances, which includes school attendance.

To the extent Petitioner's circumstances have changed and/or her representative has additional or updated information to provide, then Petitioner's representative can always request additional services in the future along with that information. With respect to the decision at issue in this case however, Department's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly reduced Petitioner's respite care services.

IT IS THEREFORE ORDERED that

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

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

[8] Although a specific time period was not provided, it appears Petitioner's conditions may have improved. At the time of the decision, Petitioner was allegedly only suffering 20 to 50 seizures a day versus the hundreds she had previously experienced every day. (See Exhibit A, p 28).

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

DHHS-Location Contact	Allegan County CMH 3285 122nd St. Allegan, MI 49010
DHHS Department Rep.	Anthony Holston Beacon Health Options Appeals Coordinator 48561 Alpha Dr # 150 Wixom, MI 48393
DHHS -Dept Contact	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913
Petitioner	[redacted], MI
Authorized Hearing Rep.	[redacted], MI