[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: August 4, 2021
MOAHR Docket No.: 21-002583
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on July 28, 2021. [redacted] and [redacted], Petitioner's parents, appeared and testified on behalf of Petitioner [redacted] (Petitioner). Stacy Coleman, Chief Privacy and Compliance Officer, appeared and testified on behalf of Respondent Macomb County Community Mental Health (Respondent or MCCMH). Christine Brothers, Clinical Supervisor, and Lisa Frentz, Petitioner's former Supports Coordinator, also testified as witnesses.

During the hearing, Petitioner's request for hearing was entered into the record as Exhibit #1, pages 1-41. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-68.

ISSUE

Did Respondent properly deny in part Petitioner's request for 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. Petitioner is a [redacted]-old Medicaid beneficiary who has been diagnosed with autism spectrum disorder, intellectual disability, obsessive-compulsive disorder, posttraumatic stress disorder, attention-deficit/hyperactivity disorder, an unspecified anxiety disorder, and other specified disorders involving the immune mechanism. (Exhibit #1, page 29; Exhibit A, page 56).

2. Due to his disabilities and need for assistance, Petitioner has been approved for services through Respondent pursuant to the Habilitation Supports Waiver (HSW). (Exhibit A, page 56).

3. Petitioner also received approximately 2.3 hours per day of Home Help Services (HHS) through the Michigan Department of Health and Human Services (MDHHS), with his father being his paid home help provider. (Testimony of Petitioner's father; Testimony of Respondent's representative).

4. As of January 1, 2020, Petitioner's services through the HSW and Respondent included 5 hours per day of respite care services and 14 hours per day of Community Living Supports (CLS). (Exhibit #1, page 30).

5. Petitioner's parents and, sometimes his brother, are his paid CLS workers. (Testimony of Petitioner's mother; Testimony of Petitioner's father).

6. His brother is also his respite care worker. (Testimony of Petitioner's mother; Testimony of Petitioner's father).

7. Respondent subsequently received a request for the reauthorization of Petitioner's approved services, including the 5 hours per day of respite care services. (Exhibit #1, pages 29-30).

8. Following a review of Petitioner's needs, Respondent decided to reduce Petitioner's respite care services from 5 hours per day to 1 hour per day. (Exhibit #1, page 30).

9. Petitioner then requested an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 30).

10. Respondent subsequently upheld the reduction in respite. (Exhibit #1, page 30).

11. Petitioner then filed a request for hearing with MOAHR and the matter was docketed by MOAHR as Docket No. 20-003264. (Exhibit #1, page 30).

12. On October 20, 2020, ALJ Robert J. Meade issued a Decision and Order in Docket No. 20-003264 in which he reversed Respondent's decision to reduce Petitioner's respite care services. (Exhibit #1, pages 28-41).

13. In part, that Decision and Order stated:

> Here, Petitioner is authorized to receive 35 hours of respite per week, or an average of five hours of respite every day, 365 days per year. While one could argue that five hours is "short-term", as in a "limited period of time" when compared to the 24

> hours of care per day Petitioner requires, five hours per day, every day can in no way be considered intermittent. Clearly, five hours of respite per day, every day, is regular and continuous. And, while there is a break of 19 hours in between each respite service, the fact that the same pattern repeats itself every day is regular and continuous.
>
> However, as improper as the respite authorization may have been, the CMH cannot simply reduce respite by 80% in the middle of a one-year IPOS agreement without doing a more thorough analysis of Petitioner's needs. Here, CMH properly identified that Petitioner's respite authorization was improper, but it did no assessment of how removing four care hours per day from Petitioner's agreed upon plan of service would affect Petitioner. All CMH did was list the other services Petitioner was authorized to receive and conclude, basically, "he will be fine." Clearly there was a reason that Petitioner was previously authorized to receive 21.25 hours of care per day between CLS, AHH, and respite. Nothing changed in the middle of Petitioner's agreed upon plan of service except that the CMH noticed that it was likely using respite improperly in Petitioner's case. When that occurs, a full assessment involving all parties must be conducted before CMH can unilaterally reduce one of those services by 80%.

Exhibit #1, pages 38-39

14. ALJ Meade also specifically ordered:

> The CMH decision is REVERSED.
>
> Within 10 days of this Order, CMH must certify that it has taken steps to begin a reassessment of Petitioner's need for respite services in conjunction with his other authorized services.

Exhibit #1, page 39

15. Following that Decision and Order, Respondent reinstated the authorization for 5 hours per day of respite care. (Testimony of Petitioner's mother).

16. Subsequently, Respondent also decided to terminate Petitioner's utilization of certain services, including respite care services through a self-determination arrangement. (Testimony of Petitioner's mother).[1]

17. Respondent further determined that it would not offer supports coordination directly and that Petitioner's supports coordination services would have to be reassigned to an outside supports coordination agency. (Testimony of Petitioner's mother).

18. Due to the change in supports coordination services, Petitioner's respite care services were only reauthorized in 30-day increments. (Testimony of Petitioner's former supports coordinator; Testimony of Respondent's representative).

19. In March of 2021, Petitioner's supports coordination services were transferred to MORC, Inc. (Exhibit A, pages 24-58; Testimony of Petitioner's former supports coordinator).

20. MORC, Inc. subsequently developed a Preliminary Treatment Plan based, at the request of Petitioner, on Petitioner's current Individual Plan of Service (IPOS). (Exhibit A, page 25, 29).

21. With respect to respite care services, that plan stated in part:

> Respite-Utilization of respite will ensure [Petitioner] is able to stay where he desires to live, his natural family home. Due to needing 24/7 direct adult supervision, natural supports need a break to be able to sleep and have time to meet individual needs within their own daily lives.
>
> * * *
>
> Due to [Petitioner's] need for constant supervision/supports at night as well, respite is needed minimally 4-6 hours per day or CLS staffing increased to provide direct supports at night from midnight to 6am due to [Petitioner] not sleeping through the night and waking 2-3 times where there are concerns regarding health and safety due to past history of breaking glass, wandering, unresponsive, sleep walking and seizure activity at night. The family does have an alarm system in the home and a chime

[1]Petitioner requested a hearing with respect to Respondent's decision to terminate self-determination, but that request was subsequently dismissed by the undersigned Administrative Law Judge on the basis that Respondent's action was not an adverse benefit determination that gives rise to the right to a Medicaid fair hearing. *See* MOAHR Docket No. 20-006715.

> that rings when he is out of bed, however he still needs direct supervision during this time
>
> * * *
>
> Respite-Family report "[Petitioner] needs his sleep monitored/supervised due to increased possibility of elopement, monitor possible seizure activity, night terrors and sleep walking and risk of falling out of bed and use of restroom."

Exhibit A, pages 29-30, 48

22. On April 6, 2021, Petitioner's new supports coordinator submitted a request for services for Petitioner for the time period of May 1, 2021, to July 31, 2021. (Exhibit A, page 62; Testimony of Clinical Supervisor).

23. In part, Petitioner requested 14 hours per day of CLS; 6 hours per day of Overnight Health and Safety Support (OHSS) services; and 35 hours per week of respite care services. (Exhibit A, page 62; Testimony of Clinical Supervisor).

24. The requests for 14 hours per day of CLS and 6 hours per day of OHSS were approved as requested. (Exhibit A, page 62; Testimony of Clinical Supervisor).

25. However, Respondent also subsequently sent Petitioner an Adverse Benefit Determination indicating that the request for respite care services had been denied. (Exhibit #1, pages 8-14; Exhibit A, pages 3-7).

26. The decision to deny the request for respite care services was made on Sunday, April 6, 2021. (Testimony of Clinical Supervisor).

27. The notice of denial was also dated April 18, 2021. (Exhibit #1, page 8; Exhibit A, page 7).

28. However, it was mailed overnight to Petitioner on April 20, 2021. (Exhibit #1, page 17).

29. With respect to the reason for the denial, the notice stated:

> Your clinician requested 35 hours per week of Respite Services for the date range of 5/1/2021 – 7/31/2021. Based on a review of the documentation in the medical record in conjunction with the Medicaid Provider Manual, it was determined that the provision of this

> service does not align with the MPM therefore it has been denied.
>
> *Exhibit #1, page 8*
> *Exhibit A, page 7*

30. In a letter dated April 22, 2021, Petitioner's representatives requested an expedited Internal Appeal with Respondent regarding the decision to deny respite care services. (Exhibit #1, pages 19-21).

31. Petitioner's representatives also requested that Petitioner's respite care services continue while the Internal Appeal was pending. (Exhibit #1, page 20).

32. Petitioner's representatives further requested that any communications be done via email and that any Internal Appeal meeting be recorded, with transcripts made available to Petitioner. (Exhibit #1, page 20).

33. On April 26, 2021, Respondent sent Petitioner a Notice of Denial of Expedited Appeal. (Exhibit #1, page 26; Exhibit A, page 14).

34. In part, that notice stated:

> The MCCMH Local Dispute Resolution (LDR) Hearing Officer has determined, after a review, to deny the above referenced consumer request for an expedited appeal received on April 23, 2021. It has been determined that taking the time for a standard resolution would not seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function.
>
> The appeal request, therefore, shall be transferred to a standard time frame, and shall be resolved within 30 days from the date that the request for an appeal was received.
>
> You have requested that the "matter" be recorded and transcribed. At this time the matter will be reviewed based upon supporting documentation. You may provide any supporting information via e-mail. Any information that you wish to have considered to

> support your position that this service is necessary should be provided to me no later than 5/17/2021.

Exhibit #1, page 26
Exhibit A, page 14

35. On April 29, 2021, in response to a request for confirmation from Petitioner's father, Respondent's representative confirmed via email that respite services should continue pending the disposition of the Internal Appeal. (Exhibit #1, page 23).

36. Respondent subsequently sent Petitioner a Notice of Appeal Denial (Partial). (Exhibit A, pages 8-13).

37. The notice was dated May 24, 2021, with a notation that the office was closed on May 21, 2021. (Exhibit A, page 8).

38. In part, the notice stated:

> ## Your internal appeal was denied
>
> Your appeal was thoroughly considered. This is to inform you that we partially **denied** your internal appeal for the service/item listed below: Respite (5 hours per day). We are approving 80 hours for the authorization period of 5/21/2012-7/31/2021.
>
> * * *
>
> ## Why did we deny your appeal?
>
> We partially **denied** your internal appeal for the service/item listed above because:
>
> Your appeal was thoroughly considered. This is to inform you that we approved your appeal in part for the service/item listed below: Respite Services.
>
> You had requested five hours per day of Respite services on 5/1/2021. The request was denied at that time. It was denied stating, "Based on a review of the documentation in the medical record in conjunction with the Medicaid Provider Manual it was determined that the provision of this service does not align with the MPM therefore it has been denied."

> This matter was reconsidered upon request of a Local Appeal on 4/23/2021. The currently approved authorizations for Medicaid Covered Specialty Supports and Services are: 14 hours per day of Community Living Supports/H2015 (CLS), 6 hours per day of Overnight Health and Safety/T2027 (OHS), 12 hours of Supports Coordination/T1016, 1 hour per week of Home Care Training/S5111, and 2 hours of Speech and Language per week. In addition, Adult Home Help Providers 2.3 hours per day.
>
> The Medicaid Provider Manual (4/1/2021) defines Respite as: Respite care services provided to a waiver beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands when they are providing unpaid care."
>
> On a daily basis, there are 22.3 hours of paid supports for [Petitioner] with a combination of Adult Home Help, Community Living Supports and Overnight Health and Safety. This allows for 1.7 hours per day that do not have paid services. [Petitioner] also receives Supports Coordination, Speech and Language and Home Care Training as well. This is not taking into consideration any other therapies that he may be receiving from his other insurers. We are aware that the receives individual therapy, but the amount was not disclosed upon request. Medicaid Covered Services may not overlap. There are ten weeks remaining in the authorization period which equates to 71 days (5/21/2021 to 7/31/2021).
>
> At this time an authorization for 80 hours of Respite will be approved from 5/21/2021-7/31/2021. In the event that there is a change in his needs, please consult with your Supports Coordinator to request additional units of Respite.

Exhibit A, pages 8-9

39. On June 1, 2021, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to Respondent's decision. (Exhibit #1, pages 1-41).

40. On June 8, 2021, Respondent sent an authorization to Petitioner's respite care services provider that the respite care authorization of 35 hours per

week is “being reinstated per directive of the Chief Compliance Officer due to the pending Medicaid Fair Hearing.” (Exhibit A, pages 57, 60).

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.
>
> *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…
>
> *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) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving services through Respondent pursuant to the Habilitation Supports Waiver (HSW). With respect to that waiver and services through it, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES [CHANGES MADE 4/1/21]**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan services. **(Revised 4/1/21)** A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.
>
> HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:
>
> - Has a developmental disability (as defined by Michigan law);
> - Is Medicaid-eligible;
> - Is residing in a community setting;

- If not for HSW services, would require ICF/IID level of care services; and

- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative **(text added 4/1/21)** service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

* * *

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may

not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.
- Assisting, supporting and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and

- Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as

bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

Respite care services are provided to a waiver eligible beneficiary 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. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "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 periods 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).

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 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 full-time. In those cases, community living supports, or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
  - Group home; or
  - Licensed respite care facility.
- Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

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. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

Pages 108-110, 124-125
(internal highlighting omitted)

Additionally, Petitioner has also been approved for OHSS through Respondent pursuant to the HSW. With respect to that service, the applicable version of the MPM provides in part:

> **2.11 OVERNIGHT HEALTH AND SAFETY SUPPORT (OHSS) SERVICES**
>
> NOTE: OHSS is not available for individuals residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian.
>
> **2.11.A. ELIGIBILITY**
>
> To be eligible for OHSS, an individual must:
>
> - Be Medicaid eligible;
> - Be enrolled in one of the following waiver programs: CWP, HSW, or SEDW;
> - Be living in a community-based setting (not in a hospital, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID], nursing facility, licensed Adult Foster Care home, correctional facility, or child caring institution); and
> - Require supervision overnight to ensure and maintain the health and safety of an individual living independently.
>
> The need for OHSS must be reviewed and established through the person-centered planning process with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety.

2.11.B. COVERAGE

For purposes of this service, “overnight” includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary’s unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the Individual Plan of Service (IPOS), encompassing both health and safety support services needed for the individual to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.

- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow an individual to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.

- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary’s overall health and welfare during the night.

- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).

- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.

- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.

- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.

- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person’s life.

- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.

- OHSS is not available for an individual who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.

- OHSS is not intended to compensate or supplant services for the relief of the primary caregiver or legal guardian living in the same home or to replace a parent's obligations and parental rights of minor children living in a family home

- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors

2.11.C. COORDINATION OF SERVICES AND CARE

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into this category of "round-the-clock" by the nature and institutional level of care required for HCBS Waiver participants. OHSS is intended to supplement other HCBS (i.e., Community Living Supports [CLS], respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the other community support services to prevent issues of duplicative services. OHSS is complementary of the other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of an individual overnight.

MPM, April 1, 2021 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Children's Serious Emotion Disturbance
Home and Community-Based Services Waiver Appendix
Pages 108-110, 124-125
(internal highlighting omitted)

While respite care, CLS and OHSS are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM 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.

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, April 1, 2021 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *Pages 14-15*

Here, in response to a request for services, Respondent initially decided to approve the requested CLS and OHSS while denying the requested respite care. Moreover, while Respondent subsequently approved some respite care services following the Internal Appeal, it was still in an amount less than what was requested and Petitioner requested an administrative hearing.

During the administrative hearing, Respondent's representative testified that, given Petitioner's approved services, including respite care, CLS, OHSS, HHS and other services, Petitioner would receive paid care approximately 24 hours a day, 7 days a week and the paid services cannot overlap. She also testified that, as part of the Internal Appeal, she made the decision to approve some respite care in consideration of the unavailability of supports and, given that occasional unavailability, it was an error for Respondent to initially not approve any respite at all. Respondent's representative further described the course of Petitioner's authorizations and Internal Appeal, including when notices were sent and her decision to only accept documentation and information from Petitioner in writing. She also conceded that an error was made in failing to continue Petitioner's respite care while the Internal Appeal or State fair hearing were pending, but that the error was corrected.

Petitioner's mother testified regarding the stress on Petitioner's parents from caring from Petitioner given his needs, including a need for two people to be with him at times; his issues with sleeping; multiple medical and therapy appointments; issues with Respondent and its attempts to retaliate against Petitioner and deny him services; difficulties in finding and training staffing for Petitioner; and Petitioner's parents' need to maintain their household and jobs. She also testified that Petitioner is going through issues with losing some of his longtime doctors, and that Petitioner's mother herself has medical issues. She further testified that Petitioner would be in a group home receiving care 24 hours a day, 7 days a week, if not for Petitioner's parents.

She also testified that, while Petitioner has not had a caregiver from outside the family since before the Covid-19 pandemic and that his parents have been providing the paid care, their stress is not from the paid care they provide. She also raised concerns about bringing outside staff into the home given the ongoing pandemic, and testified that, even if all the paid care was provided by outside staff, Petitioner's parents would still have to be there to supervise staff and assist them at times given Petitioner's needs, size, and behaviors.

Respondent's Clinical Supervisor testified that she made the initial decision to deny respite care services and that it was based on the purpose of respite, *i.e.,* to provide short-term intermittent relief for unpaid caregivers, and the lack of need for such relief in this case given the amount of paid care Petitioner was being approved for, including a new authorization for OHSS, and the amount of time that Petitioner's two parents would be providing unpaid care. She also described the timing for her decision, but she could not recall how long she spent on Petitioner's case. She further testified that the decision was based on the authorization of services going forward and that, if there were any future issues, Petitioner could always contact Respondent again and request changes. The Clinical Supervisor also testified that Petitioner's need for assistance has not changed, but that she believed respite care should not have been approved beforehand and that, regardless, he is now approved for 6 hours per day OHSS as well, which would constitute an overall increase in his paid services.

Petitioner's former Supports Coordinator testified that she was assigned to Petitioner's case for over 11 years before it was transferred in March of 2021. She also testified that Petitioner was getting respite care services during that time, and that she felt it was a medically necessary part of his plan. She further testified that authorization requests were made on a six-month basis until near the end, when she directed by Respondent to make the requests in 1 month increments due to the upcoming change in supports coordination. The Supports Coordinator agreed that the month-to-month approvals would make it difficult to hire or retain staff, and that the Covid-19 pandemic already made staffing difficult all around. She also testified that the goals in Petitioner's plan were written so that his HHS and CLS did not overlap, and that she was told by Petitioner's parents that Petitioner could receive the services at the same time. She further testified that she requested OHSS for Petitioner previously, but that it was not approved when she was Petitioner's supports coordinator.

Petitioner's father testified that they have utilized respite care in the past and that it has helped him, especially given that he was employed as a first responder throughout the Covid-19 pandemic while providing care to Petitioner. He also testified that, even with respite services, someone else must be there and that he does not get much sleep, though he could not give specific reasons why two people must be present.

He further testified that staffing issues have put a strain on the family and that the family, Petitioner's parents and brother, are providing all of the paid care at this time. Specifically, Petitioner's father is the HHS worker; Petitioner's parents and brother are his CLS workers; Petitioner's brother is the respite worker; and Petitioner's brother and mother are the OHSS workers. Petitioner's father did testify that they cannot find supports outside of the family, despite trying, and that he has had to refuse overtime work because of Petitioner's needs.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred by partially denying the request for respite care services.

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

Petitioner was approved for approximately 8 hours per week of respite care services following the Internal Appeal and given Petitioner's other, substantial paid services, that significant amount of respite care services appears sufficient to meet Petitioner's needs and provide his natural supports with short-term, intermittent relief from the daily stress and care demands during times when they are providing unpaid care. Petitioner has been authorized for a combination of 20 hours per day of CLS and OHSS, in addition to his daily HHS, and, while Petitioner's family provides those services and they demand a lot of time, by policy respite care cannot be provided for relief for providing that *paid* care. Moreover, even if Petitioner requires two caregivers at unspecified times, one of whom would be unpaid, and there are unspecified times where CLS and HHS are being provided at the same time without overlapping, which would discount simply adding up his HHS, CLS, OHSS and respite to determining Petitioner's daily paid care, the record fails to reflect that Petitioner's parents are providing unpaid care in such an amount that 5 hours per day of respite care is medically necessary. Petitioner undisputedly requires around-the-clock care, but there are only so many hours in the day; Petitioner is receiving so much paid care; and Petitioner's representatives failed to sufficiently detail what specific unpaid care they are providing, in what specific amount, and why they need intermittent relief from it, as opposed to relief from the demands of providing paid care. Instead, Petitioner and his representatives appear to be seeking respite care as a regular part of daily care when such continuous and long-term services are not the goal or role of respite.

Petitioner also argues that Respondent was previously reversed for reducing Petitioner's respite care authorization from 5 hours per day and that nothing has changed since that reversal with respect to Petitioner's need for respite care, with Respondent also failing to conduct any subsequent evaluation that would support a reduction in respite care. However, Petitioner's argument ignores one distinct change in his circumstances that would clearly warrant a change in his respite care services. Specifically, at the time of its initial decision in this case, Respondent also approved 6 hours per day of OHSS for the first time and such paid services would clearly lessen the need for unpaid care; any stress on Petitioner's natural supports for providing such unpaid care; and, consequently, the need for respite care services. With the approval of 6 hours per day of OHSS, in addition to the reauthorization of 14 hours per day of CLS, Petitioner's paid supports actually increased overall and Petitioner's argument that nothing has changed and that 5 hours per day of respite care remains necessary is unpersuasive.

Petitioner further offered arguments that Respondent's actions in the provision of Petitioner's services or in the procedural handling of the action at issue necessitates reversal in this case, but those arguments are likewise unpersuasive.

For example, while Petitioner takes issue with Respondent's decisions to terminate Petitioner's utilization of a self-determination arrangement, have Petitioner's approved supports coordination services transferred to an outside agency and to only make previous respite care authorizations in 30-day increments, the undersigned ALJ lacks jurisdiction over those issues at Respondent's actions do not constitute adverse benefit determinations that would give rise to a State fair hearing. *See* 42 CFR 438.400; 42 CFR 438.402. Petitioner may seek other avenues of relief for those complaints, including filing a grievance pursuant to 42 CFR 438.402, but they are beyond the scope of this case.[2]

Moreover, while Petitioner argues that the initial notice of denial failed to provide him with the required 14 days of advance notice, Respondent is only required to send a notice at least 10 days before the date of action in this case[3] and Petitioner was provided with such notice, with the notice mailed on April 20, 2021, for an action effective on May 1, 2021.

Additionally, while Petitioner correctly notes that Respondent failed to adhere to the notice and timing requirements in 42 CFR 438.408 when responding to Petitioner's appeal, the remedy for that failure is not a reversal in this case. Instead, the applicable regulations merely provide that, where Respondent fails to comply with the timing requirements, Petitioner can request a State fair hearing without Respondent upholding the adverse benefit determination first, *see* 42 CFR 438.402(c)(1)(i)(A); 42 CFR 438.408(c)(3); 42 CFR 438.408(f)(1)(i), and Petitioner requested and received the State fair hearing in this case.

Finally, to the extent there was an improper gap in the authorization of respite care services while the Internal Appeal was pending in violation of 42 CFR 438.420, that error has been remedied and it does not warrant a reversal of the decision itself.

Petitioner and Respondent clearly have had a contentious relationship, and Petitioner has raised a number of concerns, but the undersigned ALJ is limited to reviewing the partial denial of respite care services at issue in this case; and, for the reasons discussed above, the ALJ now finds that Petitioner has failed to meet his burden of proving by a preponderance of the evidence that Respondent erred in partially denying Petitioner's request. Accordingly, Respondent's decision is affirmed.

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[2] With respect to this case, Petitioner at most claims that Respondent's actions in the provision of Petitioner's services made it more difficult for him to hire paid caregivers and forced his family to work as paid caregivers. However, even if that was the case, that does not change the above analysis or the fact that respite care cannot be authorized on a long-term, regular basis or to relieve caregivers from stress and care demands caused by providing paid care.

[3] *See* 42 CFR 438.404(c).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied in part Petitioner's request for respite care services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/sb

Steven Kibit
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

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
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MDHHS-BHDDA-Hearing-Notices@michigan.gov

Authorized Hearing Rep.

[redacted], MI
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DHHS-Location Contact

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Petitioner

[redacted]