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

Date Mailed: August 12, 2020
MOAHR Docket No.: 20-004081
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon a request for a hearing filed on the minor Petitioner's behalf.

After due notice, a telephone hearing was held on July 30, 2020. Attorney Simon Zagata appeared on Petitioner's behalf. Shawn Dilts, Access Supervisor, represented Respondent Shiawassee Health and Wellness.

During the hearing, the following witnesses testified: Respondent's representative; Lynette Tilson, Case Manager; and Julie Wing, Petitioner's mother.

The following exhibits were also entered into the record:

Petitioner's Exhibits

Exhibit A: Psychiatric Evaluation

Exhibit B: Person-Centered Plan (PCP) Meeting

Exhibit C: Action Notice

Exhibit D: Notice of Adverse Benefit Determination

Exhibit E: Letter regarding Local Appeal

Exhibit F: Notice of Appeal Denial

Respondent's Exhibit

Exhibit #1: Evidence Packet

ISSUE

Did Respondent properly suspend Petitioner's Community Living Supports (CLS) and 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. Respondent is a Community Mental Health Service Provider (CMHSP) associated with Mid-State Health Network, a Prepaid Inpatient Health Plan (PIHP).

2. Petitioner is a [redacted]-year-old Medicaid beneficiary who has been diagnosed with unspecified disruptive, impulse-control, conduct disorder; unspecified attention-deficit/hyperactivity disorder; high expressed emotion level within family; intermittent explosive disorder; and other specified schizophrenia spectrum other psychotic disorder. (Exhibit A, pages 1-3).

3. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Respondent, including 68 hours per month of CLS and 12 hours per month of respite care services. (Exhibit A, page 1; Exhibit B, pages 1-6; Testimony of Respondent's representative).

4. In September of 2019, following a substantiated complaint filed against it by Petitioner's family, the provider of Petitioner's CLS and respite care services discontinued providing services to Petitioner. (Exhibit C, page 1; Testimony of Case Manager).

5. Respondent also sent an Action Notice suspending Petitioner's services at that time because the provider had discontinued services. (Exhibit C, page 1).

6. Since that time, Petitioner has not received CLS or respite care services due to the lack of an available provider. (Testimony of Petitioner's mother; Testimony of Case Manager).

7. Respondent did subsequently reach out to three out-of-network provider agencies, but the agencies were either unavailable or declined to provide services. (Testimony of Case Manager).

8. Respondent also offered Petitioner's family the option of utilizing his services through self-determination, but that option was denied. (Testimony of Case Manager).

9. For the plan year of February 8, 2020 to February 7, 2021, Petitioner's Person-Centered Plan (PCP) again included CLS and respite care services. (Exhibit B, pages 1-6; Exhibit #1, pages 31-37).

10. Respondent also subsequently worked on arranging for in-network caregivers to provide some, but not all, of the approved services. (Exhibit #1, page 38).

11. However, those caregivers never provided any services due to precautions and social distancing taken as a result of the coronavirus pandemic. (Exhibit #1, page 42).

12. On March 9, 2020, Petitioner filed a Local Appeal with Respondent regarding the suspension of CLS and respite care services. (Exhibit E, page 1).

13. In response, Respondent sent a letter indicating that, while it was too late to file a Local Appeal with respect to the suspension of services in September of 2019, Petitioner was again approved for those services in February of 2020 and, because those approved services had not yet been provided, Respondent should have sent a new Adverse Benefit Determination. (Exhibit E, page 1).

14. On March 12, 2020, Respondent also sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner's CLS and respite care services were suspended because "[Respondent] does not have provider capacity to provide service(s)". (Exhibit D, page 1; Exhibit #1, pages 4-6).

15. On April 6, 2020, Petitioner filed a Local Appeal regarding that Notice of Adverse Benefit Determination. (Exhibit F, page 1).

16. On May 4, 2020, Respondent sent Petitioner a Notice of Appeal Denial in which it indicated that Petitioner's Local Appeal was being denied as Respondent was attempting to provide the CLS and respite care services, and proper notice was eventually provided. (Exhibit F, page 1).

17. On June 30, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding the suspension of his CLS and respite care services.

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 approved for both CLS and respite care services through Respondent. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
>
> - laundry
>
> - routine, seasonal, and heavy household care and maintenance
>
> - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
>
> - shopping for food and other necessities of daily living
>
> CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded

Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, 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 case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living 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 the DHS's allowable parameters. 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. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to children and youth 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.

* * *

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.

MPM, January 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 132-33, 145-147

In order to have been approved, the CLS and respite care services had to be medically necessary. *See* 42 CFR 440.230. 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.

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, January 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 14-15

Here, as discussed above, Respondent decided to suspend Petitioner's CLS and respite care services.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred.

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

It is undisputed that the approved CLS and respite care services for Petitioner are medically necessary and that the sole reasons the services were suspended were because, despite some efforts, Respondent has been unable to locate a provider for Petitioner since September of 2019 and it does not have provider capacity to provide the approved services.

However, Respondent's inability to locate a provider, either in-network or out-of-network, for Petitioner's medically necessary services is not a proper basis for a suspension of services. Respondent fails to point to any law or policy supporting its action and 42 CFR 438.206(1) specifically provides that each State must ensure that all services covered under the State plan are available and accessible to enrollees of

PIHPs in a timely manner and that each PIHP maintains and monitors a network of appropriate providers that is both supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees. Moreover, 42 CFR 438.206(4) further states that, if the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the PIHP must adequately and timely cover these services out of network for the enrollee, for as long as the PIHP is unable to provide them.

Accordingly, given the undisputed medical necessity for the approved services and the lack of any valid basis for suspending them, Respondent erred in suspending Petitioner's CLS and respite care services and its decision do so must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly suspended Petitioner's CLS and respite care services.

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED,** and it must initiate a reinstatement of Petitioner's CLS and respite care services.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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 Department Rep.

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