[redacted]
MI [redacted]

Date Mailed: December 21, 2020
MOAHR Docket No.: 20-006556
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on December 1, 2020. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf. Petitioner was also present but did not otherwise participate. Lisa Morse, Hearing Officer, appeared and testified on behalf of the Respondent Region 10 PIHP. Ellen Bartley-Robertson, Utilization Management Clinical Coordinator, also testified as a witness for Respondent.

During the hearing, it was determined that Petitioner had a proposed exhibit his representative had not submitted to the Michigan Office of Administrative Hearings and Rules (MOAHR). Petitioner's representative had submitted the proposed exhibit to Respondent, who did not object to its admission.

The parties and undersigned Administrative Law Judge then determined that Petitioner's exhibit would be admitted as Exhibit A; the hearing would proceed as scheduled, with the undersigned Administrative Law Judge not yet having the exhibit; and Respondent would forward the exhibit to MOAHR by December 11, 2020.

The hearing was completed as scheduled on December 1, 2020 and the record was left open until December 11, 2020 so that Respondent could forward Petitioner's exhibit. Respondent subsequently forwarded the exhibit and the record closed.

Overall, the following exhibits were entered into the record:

Exhibit A: Petitioner's Evidence Packet
Exhibit B: Request for Hearing

Exhibit #1: Hearing Summary
Exhibit #2: Medicaid Eligibility Review

Exhibit #3: Medicaid Provider Manual Excerpt
Exhibit #4: Medicaid Provider Manual Excerpt
Exhibit #5: Adverse Benefit Determination Notice
Exhibit #6: PIHP Appeal Resolution Letter
Exhibit #7: Respite Assessment
Exhibit #8: Individual Plan of Service Safeguard Plan
Exhibit #9: Utilization Management Determination Note
Exhibit #10: Independent Home Care of Michigan Letter

ISSUE

Did Respondent properly deny Petitioner's request for the reauthorization of 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] year-old Medicaid beneficiary who has been diagnosed with Autism Spectrum Disorder. separation anxiety, social anxiety, and post-traumatic stress disorder. (Exhibit A, page 1; Exhibit #1, pages 1-2; Exhibit #7, page 3).

2. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Respondent, including 60 hours per month of Community Living Supports and 28 hours per month of respite care services. (Exhibit #7, page 2).

3. Since March of 2020, Petitioner's CLS and respite care services stopped due to health and safety reasons arising out of the COVID-19 pandemic, with Petitioner's provider, Independent Home Care of Michigan, LLC, initially stopping services due to the state mandated shutdown and Petitioner's mother subsequently declining services after the provider reopened on June 27, 2020 because she was not comfortable with them. (Exhibit #10, page 1).

4. On September 14, 2020, Petitioner's Case Manager (CM) Kenda Jackson completed a Respite Assessment with respect to Petitioner. (Exhibit #7, pages 1-5).

5. During that assessment, she found that Petitioner does not go to school[1]; he lives with his mother, who is his sole informal support; his mother has a

[1] Petitioner completed high school but was deemed eligible for special education services while there. (Exhibit A, pages 1-42).

disability that prevents the provision of care; he requires nighttime interventions; he engages in verbal abuse weekly; he engages in property destruction/disruption weekly; he requires reminding and coaxing to complete tasks or engage in activities; and he requires total physical assistance with grooming. (Exhibit #7, page 2-5).

6. The Case Manager also checked that Petitioner was non-verbal, but further wrote that Petitioner is able to talk and just does not like talking. (Exhibit #7, page 5).

7. The Case Manager further wrote:

> Due to his Autism Spectrum Disorder, [Petitioner] requires full time care and supervision. His mother is his only full-time caregiver and she is responsible for ensuring that [Petitioner] is safe and that all of his material needs are met and his care is provided for. His father is incarcerated and not involved in his life at all. [Petitioner] does not attend to his own care or personal hygiene on his own. He is very dependent on his mother for all of his care and material needs. Respite care will be used to provide [Petitioner's] mother with intermittent breaks from the demands of constant caregiving.

Exhibit #7, page 1

8. On the same day, the Case Manager also completed an Individual Plan of Services Safeguard Plan in which she noted that Petitioner is kept safe in the community by never being alone, but that he can be left alone at home for short periods of time. (Exhibit #8, page 1).

9. Following those assessments, the Petitioner, through his Case Manager, requested the reauthorization of his respite care services. (Testimony of Utilization Management Clinical Coordinator).

10. On September 15, 2020, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that Respondent was denying Petitioner's request for respite care services on the basis that the "clinical documentation provided does not establish medical necessity." (Exhibit #5, pages 1-4).

11. On September 30, 2020, Petitioner requested an Internal Appeal with Respondent regarding that decision. (Exhibit #6, page 1).

12. On October 5, 2020, Respondent completed a Utilization Management Determination Note in which it stated in part:

> This person is now an adult with MI designation, but has never taken psychiatric medication or had a psychiatric crisis. He graduated HS on time and was reported always to have good behavior and no problems. He does not have a valid diagnosis for services with three rule outs since entering services in 2013 and a screen for Asperger's Syndrome done by Dr. Warner in 2013. There is no SCQ or documentation for special education for any reason. He does not have a guardian.
>
> When I reviewed the respite assessment, I also reviewed many of the previous ones. The CM cuts and pastes, and seems to randomly check items for behavior and self-care. All documentation supports cooperative attitude with no behavioral problems. Suddenly, the CM reported this time that he is verbally abusive and non-verbal. Nothing supports either of those claims in CHIP record.
>
> I found the respite assessment to be unreliable so did not add it since the basic requirements for an adult are not there, a valid diagnosis, medical necessity and guardianship. If anything, he could have more CLS which is respite because the mother does not have to be present.
>
> I don't see how he could graduate on time from school, not be in special education, or on meds and meet medical necessity. There is no supporting documentation to meet medical necessity for respite other than the respite assessment itself which does not match other documentation and largely cut and paste items from years ago.

Exhibit #9, page 1

13. On October 8, 2020, Respondent sent Petitioner a Notice of Appeal Denial stating that the Petitioner's Internal Appeal had been denied. (Exhibit #6, pages 1-2).

14. Specifically, the notice stated in part:

> Based on further review, the decision to deny Respite Services was appropriate at this time. The GHS Utilization Management Department completed a timely, thorough, and appropriate assessment of your case. You do not meet medical necessity criteria to receive Respite Services at this time.

Exhibit #6, page 1

15. On October 21, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding Respondent's decision. (Exhibit B, pages 1-3).

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 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**
>
> 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, July 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 148-149

While respite care is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *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, July 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 14-15

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.
>
> **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 . . .
>
> *MPM, July 1, 2020 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services*
> *pages 131-132*

Here, as discussed above, Respondent decided to deny Petitioner's request for the reauthorization of respite care services and Petitioner then requested the administrative hearing in this matter with respect to that decision.

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

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.

Respite care services are approved on a short-term, intermittent basis in order to provide a beneficiary's primary caregivers with relief from daily stress and care demands, and, while Petitioner's mother described some stress from caring for Petitioner, the vast majority of her testimony related to how the services benefited Petitioner, which is not the purpose of respite care and fails to support Petitioner's case. Petitioner's mother testimony and argument would be better addressed toward services like Community Living Supports.

Moreover, to the extent Petitioner and his mother are seeking respite care services to provide Petitioner's mother with relief, the record fails to sufficiently demonstrate that the services are medically necessary. As noted by Respondent's witness, the respite assessment itself contains significant contradictions within it regarding Petitioner's behaviors and needs, and even Petitioner's mother did not support the more severe

findings identified in the assessment. Respondent's witness similarly and credibly testified that the remainder of Petitioner's record did not support the request for respite care services and, while the documents from Petitioner's school do demonstrate that he was approved for special education in the past, neither that past approval nor the fact that Petitioner was previously approved for respite care services alone a warrant a reauthorization of services.

To the extent Petitioner's circumstances have changed or he and his mother have additional information to provide in support of a need for respite care services, then they can always submit another request for such services in the future along with that information. With respect to the decision at issue in this case however, Respondent'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 Respondent properly denied Petitioner's request for the reauthorization of respite care services.

IT IS THEREFORE ORDERED that

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

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 -Dept Contact

Belinda Hawks
320 S. Walnut St.
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DHHS Department Rep.

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