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Date Mailed: April 22, 2021
MOAHR Docket No.: 20-006643
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 hearing via video conferencing was begun on February 25, 2021. However, the hearing could not be completed during the allotted time and it was determined that it must be continued later. After due notice, the hearing was subsequently continued and completed via video conferencing on March 25, 2021.

[redacted] Authorized Hearing Representative, appeared on Petitioner's behalf during the hearing. Stefanie Zin, Fair Hearings Officer, represented the Respondent Community Mental Health Authority of Ingham, Eaton and Clinton County (CMHA-CEI).

During the hearing, the following witnesses testified:

Petitioner's Witnesses

[redacted] Petitioner's mother and legal guardian

[redacted] Petitioner's father

[redacted] caregiver

Katie Dietrich, Director of Programs at Forster Woods

[redacted] Petitioner's sister

Respondent's Witnesses

Dawn Eccles, Senior Supports Coordinator

Carrie Anderson, Life Consultations Coordinator

Drew Kersjes, Residential Supervisor

Marie Carrell, Supervisor of Life Consultation Unit

Also present during the hearing were Petitioner; Colleen Allen, President at the Autism Alliance of Michigan; and Karla Bloch, Director of Community Services for Respondent.

The following exhibits were entered into the record during the hearing:

Petitioner's Exhibits[1]

Exhibit #1: Memo from Department of Health and Human Services (DHHS) dated March 19, 2019

Exhibit #2: Letter from DHHS dated July 30, 2015

Exhibit #3: November 2019 to November 2020 Treatment Plan Timeline

Exhibit #4: Time Study for Week of October 19, 2020

Exhibit #5: Medical Documentation

Exhibit #6: Full Life Level of Care (FLLOC) and Outcome, February 11, 2020

Exhibit #7: FLLOC and Outcome, August 21, 2020

Exhibit #8: Emergency Services FLLOC, August 7, 2020

Exhibit #9: Treatment Plan Addendum-Review dated February 19, 2020

Exhibit #10: Treatment Plan Addendum-Review dated February 26, 2020

Exhibit #11: Treatment Plan Addendum-Review dated May 15, 2020

Exhibit #12: Treatment Plan Addendum-Review dated August 21, 2020

Exhibit #13: Treatment Plan dated November 19, 2019

Exhibit #14: Supports Intensity Scale Assessment Report

[1] Many of Petitioner's exhibits had notes handwritten on the original documents. The proposed exhibits were still admitted, with Petitioner's mother/guardian later testifying that she wrote the notes.

Respondent's Exhibits

Exhibit A: Request for Hearing

Exhibit B: CMHA-CEI Procedure 3.3.25G

Exhibit C: Bio-Psycho-Social Assessment dated October 4, 2019

Exhibit D: Full Life Level of Care (FLLOC) completed in November of 2019

Exhibit E: Treatment Plan dated November 19, 2019

Exhibit F: FFLOC Outcome dated February 11, 2020

Exhibit G: Email Correspondence dated July 27, 2020

Exhibit H: FFLOC dated completed in August of 2020

Exhibit I: FFLOC Outcome dated August 21, 2020

Exhibit J: Treatment Plan Addendum-Review dated August 21, 2020

Exhibit K: Email Correspondence dated August 21, 2020

Exhibit L: Neurologist Progress Note dated September 1, 2020

Exhibit M: Bio-Psycho-Social Assessment dated October 30, 2020

Exhibit N: Section 17.3.B from Medical Provider Manual, October 1, 2020 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

Exhibit O: Section 17.3.I from Medical Provider Manual, October 1, 2020 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

Exhibit P: Section 2.5.D from Medical Provider Manual, October 1, 2020 version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

ISSUE

Did Respondent properly deny in part Petitioner's request for 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. Petitioner is a [redacted] year-old Medicaid beneficiary with a legal guardian who has been diagnosed with, among other conditions, intellectual developmental disorder, severe; Autism Spectrum Disorder; cerebral palsy, unspecified; generalized idiopathic epilepsy and epileptic syndrome, intractable, without status epilepticus; generalized anxiety disorder. (Exhibit A, pages 7-11; Exhibit H, page 5).

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 H, page 3).

3. As of October of 2019, Petitioner was approved for 36 hours per week of CLS and 48 hours per week of respite care services through Respondent. (Exhibit D, page 1).

4. Petitioner also received approximately 23.5 hours per week of Home Help Services (HHS) through the Michigan Department of Health and Human Services (MDHHS or Department), with his parents being his paid home help providers. (Exhibit D, page 1; Testimony of Petitioner's mother/guardian).

5. Petitioner's parents would also provide any other necessary care as unpaid supports, though his mother works full-time outside of the home and his father is disabled. (Exhibit D, page 1; Testimony of Petitioner's father).

6. On October 4, 2019, Petitioner's Case Manager with Respondent at the time completed an assessment with respect to Petitioner. (Exhibit C, pages 1-11).

7. As part of that assessment, the Case Manager determined that Petitioner requires supports in all areas of his life, including health and safety, activities of his choosing, personal care tasks, and activities of daily living. (Exhibit C, page 1).

8. She also found that Petitioner engages in unintentional self-harm as he lacks the cognitive insights and abilities to recognize harm or danger; he can unintentionally cause property or possession damage due to his physical limitations, he needs physical supports to complete daily tasks, including supports from two people at times; he must be monitored closely during meals due to his swallowing issues; and his health needs must be closely monitored, including his risk of seizures. (Exhibit C, pages 3-9).

9. On November 19, 2019, the Case Manager also held a Person-Centered Planning meeting with Petitioner, his family, and his service providers. (Exhibit #13, pages 1-111; (Exhibit E, pages 1-9).

10. At that time, Respondent reauthorized Petitioner's services at the previous level, *i.e.*, 36 hours per week of CLS and 48 hours per week of respite care, for three months so that a Full Life Level of Care (FLLOC) Outcome could be completed with respect to medical necessity. (Exhibit E, pages 2-3).

11. At that time, Petitioner and his guardian were requesting 57.5 hours per week of CLS and 48 hours per week of respite care services. (Exhibit D, page 3).

12. Respondent further completed a FLLOC assessment in November of 2019. (Exhibit D, pages 1-5).

13. In that assessment, Respondent found that Petitioner requires full assistance for medical appointments, specialty medical needs, community integration, health and safety, socialization, and personal care. (Exhibit D, page 2).

14. Respondent also found that Petitioner required limited or partial assistance with his frequent property destruction, daily self-abuse, and daily disruptive behavior. (Exhibit D, page 2).

15. Respondent also noted that Petitioner's father is disabled and that his mother works full-time. (Exhibit D, pages 3-4).

16. In February of 2020, Respondent determined that Petitioner should be approved for 56 hours per week of CLS and 48 hours per month of respite care. (Exhibit #3, page 1; Exhibit F, page 1).

17. However, Petitioner's guardian disagreed with that determination and Petitioner's services were again authorized at the previous level, *i.e.*, 36 hours per week of CLS and 48 hours per week of respite care, for another three months so that a new FLLOC assessment could be completed. (Exhibit #9, pages 1-10; Exhibit #10, pages 1-11; Exhibit J, pages 1-7).

18. In May of 2020, Petitioner's services were again authorized at the previous level, *i.e.*, 36 hours per week of CLS and 48 hours per week of respite care, for another three months due to a health advisory related to the COVID-19 pandemic and pending a new FLLOC outcome. (Exhibit #11, page 1-10; Exhibit J, pages 1-7).

19. On June 19, 2020, Respondent completed a Supports Intensity Scale Adult Version (SIS-A) assessment with respect to Petitioner. (Exhibit #14, pages 1-18).

20. As part of that assessment, it found that Petitioner requires full physical supports for socialization, both within his household and in the community; transportation; participating in community activities; shopping; using public services; learning skills; using technology; participating in training; avoiding health and safety hazards; accessing emergency services; ambulating; maintaining emotional well-being; taking medications; maintaining a nutritious diet; maintaining physical health; obtaining health care services; using appropriate social skills, communicating; advocating for self; making choices and decisions; protecting self from exploitation; managing money and personal finances; and obtaining services. (Exhibit #14, pages 3-11).

21. Respondent also found that Petitioner requires extensive support with oral stimulation; turning or positioning; transferring; therapy services; prevention of emotional outbursts; prevention of assaults or injuries to others; prevention of property destruction; prevention of ingestion of inedible substances; his daily routines (Exhibit #14, pages 11-12).

22. Respondent further found that Petitioner requires some support with prevention of stealing; self-injury; and nonaggressive, but inappropriate sexual behavior. (Exhibit #14, page 12).

23. In a letter dated July 21, 2020, a Nurse Practitioner at the Michigan Medicine Neurology Clinic, where Petitioner was being treated, wrote in part that:

> [Petitioner] is [redacted]year-old male with history of global developmental delay, autism, cerebral palsy, and seizures since 3 years of age. He is nonverbal and requires assistance with all activities of daily living. He must have care and supervision 24/7. He is totally disabled and dependent on his parents. Due to the high demands for care that [Petitioner] requires, it is medically necessary that his parents be provided with respite care services.
>
> *Exhibit #5, page 1*

24. A FFLOC assessment meeting was scheduled for July 24, 2020, but it was subsequently canceled after Petitioner was taken to the hospital that day. (Exhibit #3, page 2).

25. Petitioner was hospitalized from July 24, 2020 to August 6, 2020. (Testimony of Petitioner's mother/guardian).

26. In a letter dated August 5, 2020, a doctor at the hospital where Petitioner was admitted wrote in part that: "[Petitioner] is currently hospitalized following unresponsive events related to epilepsy. [Petitioner] is now requiring increased medical monitoring and additional assistance with activities of daily living." (Exhibit #5, page 2).

27. On August 7, 2020, following Petitioner's discharge from the hospital, Petitioner's Case Manager at the time completed an assessment meeting for the FLLOC with Petitioner, his family, and his service providers. (Exhibit #8, pages 1-2).

28. In letter submitted as part of that meeting, Petitioner's guardian and sister wrote that, with Petitioner's discharge from the hospital, he would like increased CLS for:

> assistance with establishing and maintaining a new baseline of skills, abilities, behaviors and medical stability following the successful transition to new seizure and behavior medications, which will be managed by his U of M neurologist and psychiatrist for an undetermined amount of time.
>
> *Exhibit #8, page 1*

29. They also wrote that specific areas where Petitioner was seeking assistance included gaining strength, endurance and coordination for activities of daily living; monitoring for seizure activity; help with personal care tasks; socialization; and building communication skills. (Exhibit #8, page 1; Testimony of Petitioner's sister).

30. They further wrote that Petitioner continued to require assistance with all activities and 24/7 monitoring for health and safety reasons. (Exhibit #8, page 1; Testimony of Petitioner's sister).

31. In August of 2020, Petitioner's Case Manager also completed the FLLOC. (Exhibit H, pages 1-8).

32. When doing so, she indicated that she had previously interviewed Petitioner's family and other caretakers in July and August of 2020. (Exhibit H, page 1).

33. She also indicated that she reviewed medical visit notes from July and August of 2020; the SIS-A completed June 19, 2020; the previous case

manager's assessment completed on October 4, 2019; Petitioner's PCP dated May 15, 2020; and the previous FLLOC completed in November of 2019. (Exhibit H, page 1).

34. In the FLOC, the Case Manager found that Petitioner required full assistance with medical appointments; his specialty medical needs; community integration; health and safety; socialization; and his personal care, including bathing, dressing, eating/feeding, grooming, laundry, light housework, meal preparation, medications, mobility, shopping, toileting, and transferring. (Exhibit H, page 2).

35. She also found that Petitioner engages in daily physical aggression, property destruction, disruptive behaviors; monthly self-abuse; and occasional sexually inappropriate behavior. (Exhibit H, page 2).

36. She further found that Petitioner's parents provide full hands-on support when paid staff are not present, including sleep time supervision. Including monitoring ability to fall and stay asleep, track and report changes in his sleep patterns to his neurologist and psychiatrist. (Exhibit H, pages 3-4).

37. She also noted that, with, Petitioner's discharge from the hospital, he would like assistance with establishing and maintaining a new baseline of skills, abilities and behaviors. (Exhibit H, page 3).

38. Overall, she recommended that Petitioner be approved for 52.5 hours per week of CLS and 48 hours per week of respite care. (Exhibit H, page 3).

39. The completed FLOC also identified Petitioner's week as including 21 hours per week of natural supports; 19.25 hours per week of Adult Home Help; 70 hours of other unpaid supports, such as "sleep, time, alone, independent, etc.", and 50.75 hours of unmet need. (Exhibit H, page 7).

40. With respect to Petitioner's unmet needs, the FLLOC also expressly provided:

> [Petitioner] has significant health, safety, & medical needs which would result in serious problems/death without a responsible and properly trained caregiver present. [Petitioner] requires constant monitoring and supervision for health and safety – even in the hours that he is asleep. Missing hours: 5.25 – AHH. 1.75 – Unmet Need
>
> *Exhibit H, page 7*

41. On August 21, 2020, Respondent completed its FLLOC Outcome and determined that Petitioner's CLS should be approved for 60 hours per week for one month, then transitioned down to 56 hours per week. (Exhibit I, pages 1-2).

42. Respondent further found that Petitioner's respite care should be approved for two weekends a month for ninety days, then approved for one weekend per month. (Exhibit I, pages 1-2).

43. That same day, Respondent also sent Petitioner a letter and Adverse Benefit Determination regarding his services. (Exhibit K, pages 1-8).

44. In part, the letter stated:

> The request for the increased funding for CLS and Respite hours of support has been partially approved at this time as additional services and supports are in place to meet the needs to include the following items:
>
> - Exception approval of additional hours of CLS will be for a 60-day period as follows:
> - 60 hours of CLS weekly for one month (8/21/20-9/30/20)
> - 58 hours of CLS weekly for one month (10/1/20-10/31/20)
> - 56 hours of CLS weekly (to begin 11/1/20).
> - Exception approval of additional hours of Respite will be for a 90-day period as follows:
> - Two weekends (48 hours) per month for a period of 90-days (8/21/20-11/21/20. [sic]
> - On weekend (48 hours) per month to begin 11/21/20.
> - A portion of your Adult Home Help authorization through MDHHS has been identified to be in transition to the current provider of your choice . . .
>
> * * *
>
> The CLS exception is authorized to assist with the transition into the living environment of you choice and will be in effect for 8/21/20 –

> 11/20/20. The Respite exception authorization will be in effect from 8/21/20-11/21/20.
>
> *Exhibit K, pages 4-5*

45. The Adverse Benefit Determination identified the same decisions with respect to CLS and respite, while also stating that the "clinical documentation provided does not establish medical necessity" for the requested services. (Exhibit K, page 6).

46. On August 28, 2020, Petitioner's guardian requested an Internal Appeal with Respondent. (Exhibit A, page 4).

47. On October 9, 2020, Respondent sent Petitioner's guardian written notice that her Internal Appeal had been denied. (Exhibit A, pages 4-6).

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

> LACK OF MEDICAL NECESSITY: Per the Notice of Adverse Action dated 8-21-20, "a denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit."
>
> It was noted that, "If Respite is being utilized in-home this cannot be provided while primary caregivers are present in the home. The Adult Home Help hours have been requested to shift to the Provider. Additional supports offered from Sparrow at discharge included specialized in-home supports as follows, RN, PT, Home Health Aide to also support during the transition period. Please note that these services would be utilized first by the identified provider, as CLS is the Payor of Last Resort."
>
> This office has been notified that [Petitioner's] new Case Manager has not been able to connect with the family despite repeated attempts. As such CMHA-CEI will need to uphold the original Full Life Level of Care (FLLOC) determination based on the information that is currently in the possession of CMHA-CEI. This determination was predicated on [Petitioner's] identified medical

> necessity and what was determined to be clinically appropriate to meet those identified medically necessary needs.
>
> *Exhibit A, page 4*

49. On October 27, 2020, 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 A, pages 1-11).

50. Petitioner's CLS and respite care services have remained at their previous level while this matter is pending. (Exhibit #12, pages 1-12; Testimony of Senior Supports Coordinator).

51. Petitioner's parents also switched some of Petitioner's HHS hours from themselves to a different provider. (Testimony of Petitioner's mother/guardian).

52. Petitioner further submitted additional documentation to Respondent while this matter was pending and, while Respondent reviewed that information, it did not change its decision in this matter. (Testimony of Petitioner's sister; Testimony of Senior Supports Coordinator; Testimony of Life Consultations Coordinator).

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 CLS and respite care services through Respondent pursuant to the Habilitation Supports Waiver (HSW). With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> 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 state plan or additional/B3 services. 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.

* * *

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 nonvocational 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.

MPM, July 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 106, 108-109, 123-124
(underline added for emphasis)

Moreover, 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

Here, in response to a request for increased CLS, Respondent decided to both approve an increased amount of CLS for Petitioner, though not in the amount requested, and reduce Petitioner's respite care services. Petitioner then requested the administrative hearing in this matter.

In appealing that decision, 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.

With respect to Petitioner's CLS authorization, Petitioner first argues that Respondent erred by using the FLLOC. However, nothing expressly precludes the use of such a tool, so long as the decision regarding the amount, scope and duration of services is still based on medical necessity, and Respondent properly addressed medical necessity here. The FLLOC documented all the different the sources of information relied upon and, while it did identify a specific number of hours to be approved, that amount was not even what was subsequently approved, with Respondent ultimately authorizing more CLS based on other facts and circumstances.

Regarding the amount of CLS services to be authorized, 8 hours of day following a transition period, which constitutes an increase from the previous authorization, Petitioner has likewise failed to demonstrate that Respondent erred.

Petitioner failed to identify any specific need that would be unmet through the authorized hours and, while Petitioner takes issue with certain findings of the FLLOC and other documents, Respondent and Petitioner both ultimately agreed on Petitioner's general needs: 1:1 care at all times he is awake and monitoring while he is asleep. Moreover, while those general needs are undisputedly considerable and Petitioner's

natural supports undoubtedly provide significant amounts of unpaid supports, the increased authorization of CLS is also significant; Petitioner has flexibility in how he uses his hours; Petitioner has substantial natural supports through his parents; and, around the time of the decision, it was decided that more of Petitioner's HHS through the Department would be provided by someone other than Petitioner's parents, which would lessen care demands made on them.

The dispute regarding CLS primarily involves Petitioner's need for monitoring during the night, which is done by Petitioner's natural supports, and the effect that has on both the availability of Petitioner's natural supports and the need for paid CLS services at other times. However, while Petitioner's witnesses testified that Petitioner has insomnia and is frequently up at night with a need for constant interventions, that testimony does not appear to be supported by the remainder of the record. For example, while Petitioner's guardian and sister identified a general need for 24/7 care in a letter submitted as part of the assessment process following Petitioner's discharge from the hospital, Petitioner has a monitor in his room already and they did not identify specific issues with sleep or any need for interventions at night beyond monitoring and tracking Petitioner's ability to fall and maintain sleep. Similarly, other assessments or letters from medical providers may reference some difficulties falling and maintaining sleep, but nothing like testified to during the hearing and even the time log submitted by Petitioner as an exhibit reflects Petitioner sleeping over ten hours a night each night before he is woken up in the morning.

Additionally, Petitioner has failed to meet his burden of proof with respect to the reduction in respite care services given Petitioner's other services and circumstances. Fewer respite hours are warranted given the increased amount of CLS through Respondent, 8 hours a day after the transition period, and, as discussed above, the record fails to reflect the constant nighttime interventions testified to by Petitioner's parents that would substantially increase the amount of needed natural supports. Moreover, Petitioner remains authorized for a substantial amount of respite care and the authorization appears to have been sufficient to provide Petitioner's parents with short-term, intermittent relief from the daily stress and care demands during times when they are providing unpaid care.

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 CLS and respite care services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, 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

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