STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 14-012742 CMH

[redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, an in-person hearing was held [redacted]. Attorney [redacted], [redacted] appeared on behalf of the Appellant. The Appellant, [redacted], Program Manager, [redacted]), [redacted] Direct Support Staff, [redacted], Supports Coordinator, Spectrum, and Appellant's mother/guardian [redacted] testified on behalf of the Appellant.

Attorney [redacted] appeared for [redacted] the County Community Mental Health Authority for [redacted], and represented the Department of Community Health (CMH). [redacted] Fair Hearing Officer was also present for the hearing. [redacted], [redacted] Planning Director for Adults with a Developmental Disability, and [redacted], MSW, [redacted] Utilization Specialist appeared as witnesses for the Department.

ISSUE

Did CMH properly deny Appellant's request for additional Community Living Supports (CLS)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant was a[redacted]-year-old Medicaid beneficiary (DOB [redacted] at the time of the hearing. Appellant has been diagnosed with Anxiety Disorder NOS; Psychotic Disorder, NOS; Moderate Mental Retardation; Down's Syndrome; Hypothyroidism, Obesity, Atrioventricular Septal Defect; and Hypersomnia. (Exhibit D pp. 1, 5).

2. [redacted] the County Community Mental Health Authority for [redacted] (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. Appellant receives Medicaid covered services as a person with a developmental disability, including Supports Coordination, Community Living Supports (CLS), and Skill Building through a self-directed arrangement. (Exhibit 1, Individual/Family Plan of Service, p. 5 of 18; and testimony).

4. Since [redacted] Appellant has lived in a duplex (the [redacted] home) with [redacted] other women who also have developmental disabilities. The other side of the home is occupied by [redacted] women who likewise have developmental disabilities. Prior to this move, Appellant lived at home with her parents. (Exhibit 1, Individual/Family Plan of Service, p. 5 of 18; and testimony).

5. Staff is not present at the duplex when the residents are at their day programs. Appellant is out of the home from about [redacted] to [redacted] through [redacted]. (Testimony).

6. Appellant attends school through [redacted] at [redacted], which includes classroom learning, and she works at different positions in the community administered by the [redacted] (Exhibit D, p. 7, 8; Exhibit 1, Individual/Family Plan of Service, p. 4 of 18; and testimony).

7. Appellant receives a daily level of CLS, which amounts to [redacted] per day or [redacted] per year, through self-determination. (Exhibit 1, Individual/Family Plan of Service, p. 5 of 18; and testimony).

8. All of the residents of the duplex pool their CLS dollars to pay for the CLS staff that comes into the home. (Testimony).

9. On [redacted], Appellant's Supports Coordinator with [redacted] submitted a request to [redacted] on behalf of the Appellant for CLS Services for the Fiscal Year starting [redacted] at the current or "low behavioral" daily rate. [redacted], CMH Utilization Management Specialist, completed a review of the B3/CLS Behavioral Support Needs Worksheet and Social Assessment submitted by Appellant's Supports Coordinator with [redacted], and found that the information submitted did support the level of care requested. [redacted] found that the "low behavioral" level of care was supported by the documentation submitted and recommended that the Appellant be approved for CLS services at that level. [redacted] and her supervisor

signed the CLS recommendation form on [redacted] and indicated on the form their agreement with [redacted] recommendation of the "low behavioral" level of care. (Exhibit E and testimony).

10. [redacted] has a capitated Medicaid budget. Their budget for the developmentally disabled (DD) community was overspent by about [redacted] in the last fiscal year, [redacted] through [redacted] As of [redacted], the [redacted] budget for the developmentally disabled (DD) community was overspent by about [redacted]. [redacted] has no carry over dollars for the next fiscal year, and must make sure that the limited Medicaid dollars are reasonably and equitably distributed in order to serve other Medicaid beneficiaries in the DD population served by [redacted]. (Exhibit F, *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, § 17.2 and testimony).

11. On [redacted], MAHS received the Appellant's Request for Hearing. (Exhibit A).

CONCLUSIONS OF LAW

The Medical Assistance Program 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…

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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. [redacted] the County Community Mental Health Authority for [redacted] County (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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
- that are 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. [*Medicaid Provider Manual*, *Mental Health/Substance Abuse*, July 1, 2014, pp. 12-14].

The *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, July 1, 2014 specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s) [Change Made 7/1/14]

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. **(text added 7/1/14)**

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES [Change Made 7/1/14]

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 insure 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. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

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

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation. [pp. 117-118].

* * *

17.3.B. COMMUNITY LIVING SUPPORTS [Change Made 7/1/14]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. **(text added 7/1/14)**

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, reminding, 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 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 the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS 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 DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS 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 DHS 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 DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. (Emphasis added). [pp. 120-121].

In this case, it is undisputed that CLS services are medically necessary for the Appellant. On [redacted], Appellant's Supports Coordinator with [redacted] submitted a request to [redacted] on behalf of the Appellant for CLS Services for the Fiscal Year starting [redacted] at the current or "low behavioral" daily rate. [redacted], CMH Utilization Management Specialist, completed a review of the B3/CLS Behavioral Support Needs Worksheet and Social Assessment submitted by Appellant's Supports Coordinator with [redacted], and found that the information submitted did support the level of care requested. [redacted] found that the "low behavioral" level of care was supported by the documentation submitted and recommended that the Appellant be approved for CLS services at that level. [redacted] and her supervisor signed the CLS recommendation form on [redacted] and indicated on the form their agreement with [redacted] recommendation of the "low behavioral" level of care.

The witnesses for CMH provided credible evidence to show that they properly assessed the Appellant's need for Community Living Supports (CLS). [redacted] utilizes a CLS Worksheet developed over time to ensure that their limited Medicaid budget is fairly and equitably distributed to eligible individuals with intellectual disabilities within their service area. [redacted] established that they have a capitated budget, and according to the policy in the Medicaid Provider Manual quoted above, they must take into account their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these CLS services. According to policy such B3 supports and services are not intended to meet all the individual's needs and preferences.

[redacted] Appellant's Supports Coordinator with [redacted] stated that the Supports Coordinator will make the request on the beneficiary's behalf with [redacted] for the CLS services. They will choose between a B3/CLS Behavioral Support Needs Worksheet (Behavioral Worksheet or CLS Worksheet), or a B3/CLS Medical Support Needs Worksheet and submit the one that results in the highest score along with the required documentation to [redacted] in support of their request for CLS services at a low, medium, or a high level of care and the corresponding daily rate for CLS services. [redacted] stated that she reviewed this matter with the [redacted] workers who were responsible for providing the CLS services for the Appellant. She also reviewed the logs kept by the direct care staff, and then did an initial scoring of the Behavioral Worksheet, coming up with an initial score of [redacted] next reviewed the matter with [redacted] [redacted] Clinical Director and then she revised the scoring on the Behavioral Worksheet and came up with a final score of [redacted] on [redacted] Thereafter, [redacted] submitted the Behavioral Worksheet along with a Social Assessment for the Appellant with a request for a continuation of CLS services at the current level, i.e., at the low level of care daily rate.

Appellant questioned [redacted] revised scoring on the Behavioral Worksheet, in an attempt to show that the scoring should have been higher, which would have entitled the Appellant to receive CLS services at the medium level of care. Appellant questioned the intensity of the Appellant's behaviors and the frequency of staff interventions on several of the numbered items on the Behavioral Worksheet. Appellant questioned the scoring for item 2 Prevention of property Destruction, item 3 Prevention of Stealing, item 6, Prevention of Suicide Attempts (active suicide ideation), and item 7 Prevention of inappropriate sexual behavior.

[redacted] stated on the CLS Worksheet she gave the following scores for intensity of behaviors and frequency of staff interventions respectively. For item 2 the initial scores were [redacted] respectively and the final scores were [redacted] respectively. [redacted] explained the reduction in the score for the frequency of staff interventions, because the data showed that for some months there was only one incident documented and she did not find any actual property destruction, only the throwing of items and the slamming of doors. For item 3 the initial scores were [redacted] respectively and the final scores were [redacted] respectively. [redacted] explained that it was determined that stealing of common food in the group home was not to be counted, so after reviewing the written

data she lowered the score for the frequency of staff interventions. For item 6 the initial scores were [redacted] respectively and the final scores were [redacted] respectively. [redacted] explained that she lowered the scores, because her notes indicated the Appellant had cut herself and talked about wanting to be dead, but the incident occurred at the beginning of the documented period and therefore the intensity of the behavior and the intervention for suicidal ideation was infrequent, so she lowered the scores for this item. For item 7 the initial scores were [redacted] respectively and the final scores were [redacted] respectively. [redacted] stated she lowered the scores, because the documented behaviors occurred in the home and they were directed towards the staff, the Appellant tried to kiss the CLS staff and she indicated wanted staff to marry her.

[redacted] Program Manager who oversees the Appellant's group home, [redacted] one of the Direct Support Staff who works in the Appellant's group home, and the Appellant's mother all provided general testimony concerning the Appellant's behaviors. [redacted] testified that the Appellant engages in property destruction weekly, she engages in acts of stealing on a weekly to daily basis, Appellant has verbal outbursts on a weekly to daily basis, Appellant expresses verbal outbursts twice monthly, and the Appellant engages in sexually inappropriate behaviors, such as referring to the CLS staff as sexy. [redacted] agreed that she couldn't give an accurate accounting of the Appellant's behaviors without documentation. She also indicated her estimates on the intensity of the Appellant's behaviors were based on what the staff tells her along with her own observations.

[redacted] one of the Direct Support Staff who works varying shifts in the [redacted] home testified that she would see the Appellant on a daily basis either in the home or on community outings. [redacted] stated there is always CLS staff in the [redacted] home when residents are present, and at times there may be [redacted] or [redacted]e staff members in the home at the same time. [redacted] testified the Appellant would engage in acts of theft on a daily basis, for example taking others shoes, their lunches, staff's keys, books, and a cell phone. She said the Appellant would engage in acts of verbal aggression such as protesting getting out of bed in the morning, and other things directed at the staff and other house mates. She further indicated Appellant's tone of voice might be aggressive or threatening, and that she also uses foul language about [redacted] times per week. [redacted] said property destruction was a problem. [redacted] indicated the Appellant throws things in the trash, knocks things over, and slams doors and desk drawers. It was reported that on one occasion the Appellant broke a desk drawer and slanted the legs on the desk. She said the Appellant engages in these behaviors weekly. [redacted] said the Appellant engages in acts of sexual aggression such as commenting to a staff person that their boobs look good in a particular shirt. She said this might occur twice a week or even several times per day. Finally, [redacted] gave an example of the Appellant's self injurious behavior stating that she might say she wants to hurt herself or that she wants to die.

Appellant's mother testified that the Appellant moved out of their home and into the [redacted] home in [redacted] Appellant's mother said Appellant generally stays at their home on holidays, and comes home on weekends when her brother is

around. Appellant's mother said she will go to the [redacted] home on occasions such as to set up the Appellant's TV, or to complete repairs to items damaged by the Appellant. Appellant's mother said the Appellant only committed acts of destruction occasionally at home because they prevented such behaviors. She said the Appellant needed daily interventions due to her anxiety disorder. Appellant's mother said she was aware that the Appellant damaged a laundry basket, tore handles off a dresser, removed a vent from the wall and damaged the dry wall, and cut the cord off an alarm clock. She said to her knowledge these things occur monthly. Appellant's mother said the Appellant engaged in acts of theft while at home, and thinks these behaviors have increased due to lack of interventions by staff at the [redacted] home. She said she believes these behaviors occur daily. Appellant's mother said Appellant engages in verbal outbursts, swearing, slamming doors and stamping her feet daily to weekly. She also related examples of inappropriate sexual behaviors such as approaching men with hairy chests, or in business suits, and flirting with them or approaching them, playing with their ties, and saying she wants to marry them. She also related that Appellant has written love letters to her teachers and wanted to kiss them. Appellant's mother said the Appellant likes breasts and will comment on them. She said these behaviors occur weekly. As for suicidal ideation, Appellant's mother said the Appellant says she doesn't want to have Down's syndrome and would prefer to be dead, but has no plan for killing herself.

[redacted] stated in preparation for the hearing she had the opportunity to review additional supporting documentation, i.e., the daily logs under the Appellant's name kept by the CLS workers at the [redacted] home for the Appellant for the [redacted] months prior to [redacted] Based on the written documentation, [redacted] stated she would have further reduced the Appellant's score on the CLS Worksheet, possibly placing the Appellant in the borderline of low level of care, or down to the [redacted]-minute units for CLS services. [redacted] found that the logs kept by the CLS workers at the [redacted] home did not substantiate the intensity of the Appellant's behaviors as indicated by the Appellant's witnesses during the hearing. [redacted] stated as for item 2 Prevention of property destruction the logs showed the Appellant ripped up some valentine decorations and broke a picture frame during the [redacted] months under review. For item 6, there was only one reference to self harm or suicidal ideation logged on [redacted]. The entry in the log was ambiguous, indicating the Appellant had cut her wrist, and that the Appellant was feeling frustrated and had thoughts to kill herself. [redacted] stated the entry in the log did not make it clear if the cut on the wrist was the result of an accident at her work site, or if it was an attempt by the Appellant to harm herself or was an actual attempt to commit suicide. [redacted] said she would have reduced the score for item 9 Prevention of verbal outbursts as the documentation showed that most of the documented incidents were not verbally aggressive behavior; rather they related to appropriate outbursts to related events, and there was only one occasion where the Appellant called one of the staff a dummy. Finally, for item 12, she would have reduced the score because there was no documentation that the staff was assisting the Appellant with her with her homework.

The Appellant bears the burden of proving by a preponderance of the evidence that additional CLS services are medically necessary. The Appellant's witnesses were given an opportunity to prove why additional CLS services are necessary. The testimony of the Appellant's witnesses and the exhibits admitted at the hearing did not establish medical necessity above and beyond the level of CLS services currently authorized by CMH in accordance with the Code of Federal Regulations (CFR).

The CMH must authorize CLS services in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it authorized CLS for the Appellant at the "low medical' level of services, in addition to the other Medicaid services the Appellant has been authorized to receive. Based upon the totality of the evidence, including the professional opinions of the CMH staff, the CLS services authorized are more than sufficient to meet the Appellant's needs for CLS services.

While the Appellant attempted to challenge the scoring on the Behavioral Worksheet through the testimony of their witnesses in an attempt to establish that the Appellant should have received CLS services at a higher daily rate, CMH provided reliable evidence that their approval at the low level of care daily rate may actually be overly generous, and that based on the available documentation in the Appellant's CLS logs, Appellant might actually qualify for a lower amount of CLS services authorized in [redacted]-minute units. More importantly, however, the Appellant's evidence was lacking any proof that the Appellant had unmet needs for CLS services, or that any of the CLS goals in her IPOS were not being met by the CLS services authorized in this case at the low level of care. Appellant has been approved a daily rate for CLS services in the amount of [redacted] per day or [redacted] per year, through self-determination. Furthermore, these funds are pooled with the funds from the other residents of the [redacted] home, and together the funds provide more than adequate CLS services for the Appellant in this case.

It also must be noted that the CLS services are being authorized as B3 services. As stated above in the policy quoted from the Medicaid Provider Manual, B3 supports and services are not intended to meet all the individual's needs and preferences. Also the CMH is required to take into consideration their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

The Appellant has failed to prove by a preponderance of the evidence that additional CLS services are medically necessary. The preponderance of the evidence demonstrates that CMH properly determined that CLS services at the "low medical" level of care are more than sufficient to meet the Appellant's need for CLS services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that CMH properly denied the Appellant's request for additional Community Living Supports (CLS).

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed [redacted]

WDB/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.