STAT E 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. 14-015403 CMH

[redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted]. [redacted] Appellant's mother, appeared and testified on Appellant's behalf. [redacted], Appellant's father, also testified as a witness for Appellant. The Appellant was present for the hearing, but did not participate. [redacted], Medicaid Fair Hearings Officer, represented the Respondent [redacted] County Community Mental Health Authority (CMH). [redacted] attorney; [redacted] Family Services Director; and [redacted] Supports Coordinator; from Community Living Services, Inc. also testified as witnesses for Respondent.

ISSUE

Did the 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. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to beneficiaries who reside in its service area.

2. In turn, it contracts with Community Living Services, Inc. to provide and oversee services.

3. Appellant is an [redacted] year-old (DOB = 9[redacted] male who has been diagnosed with Autistic Disorder; Attention Deficit Hyperactivity Disorder; and Severe Intellectual Disability. (Exhibit 2, page 9; Exhibit A, pages 1, 56).

4. He lives with his parents and his [redacted] year-old younger brother, who has been diagnosed with Asperger's Syndrome. (Exhibit A, pages 21, 29).

5. Appellant attends school [redacted] hours per week and is eligible to receive special education services until he is [redacted] years-old. (Exhibit A, pages 26, 30, 35).

6. Appellant is non-verbal, except for a few words, and has a history of engaging in challenging behaviors, including sexually inappropriate behaviors, physical aggression, and property destruction. (Exhibit 1, page 2; Exhibit A, page 26).

7. He also requires assistance with all activities of daily living and personal care, and needs to be monitored for safety and protection reasons. (Exhibit A, pages 26, 37; Testimony of [redacted]).

8. At all times relevant to this action, Appellant has been receiving services through the CMH and Community Living Services, Inc. (Exhibit A, pages 28-47).

9. Prior to his [redacted] birthday, Appellant's services were authorized through the Children's Home and Community Based Services Waiver Program (CWP). (Exhibit A, page 21).

10. Through the CWP, Appellant's services included CLS, [redacted] hours a day when in school and [redacted] hours per day when out of school for 5 consecutive days, and respite care services, [redacted] hours per month. (Exhibit A, pages 34, 38).

11. When Appellant turned [redacted] years-old on [redacted] he transitioned from the CWP to the Habilitation Supports Waiver (HSW). (Exhibit A, page 21).

12. Appellant, his parents, and his case manager started planning for that transition as early as [redacted] (Exhibit A, page 54).

13. On [redacted], prior to the transition date, [redacted] Appellant's case manager, held a Personal Plan meeting with Appellant, his parents, and one of his care residential providers. (Exhibit A, page 28).

14. During that meeting, T[redacted] noted that Appellant's staff assists with his daily living skills, community integration, management of behaviors, and safety needs. (Exhibit A, page 34).

15. [redacted] also informed Appellant and his parents that, once Appellant transitioned from the CWP to the HSW, he would no longer be eligible for [redacted] hours per month of respite care services and would instead only receive a total of [redacted] per month to be used for intermittent relief. (Exhibit A, page 38; Testimony of [redacted]).

16. [redacted] further noted that Appellant would apply for Adult Home Help Services (HHS) after he turned [redacted] years-old. (Exhibit A, page 41).

17. In response to the change in respite care services, Appellant's parents requested that Appellant's CLS services be increased so that the CLS staff could provide the necessary assistance when his natural supports, *i.e.* his parents, were unavailable. (Exhibit 2, page 3; Testimony of [redacted] Testimony of Appellant's mother).

18. As support of that request for additional CLS hours, Appellant's mother provided written narratives and a written medical justification. (Testimony of [redacted]

19. In those documents, Appellant's mother wrote that, while the frequency of Appellant's bad behaviors had decreased with the supports he was receiving, the intensity of the behaviors had not and Appellant still required [redacted] care and monitoring. (Exhibit A, page 1).

20. Appellant's mother also wrote that, due to Appellant's size, she can no longer handle him by herself and that she works as a flight attendant, with trips out-of-town for up to [redacted] days at a time, [redacted] to [redacted] times a month. (Exhibit A, page 1).

21. Appellant's mother further wrote that Appellant's father has health problems and cannot be the primary caregiver for Appellant. (Exhibit A, page 1).

22. Appellant's parents also provided a letter from Appellant's father's doctor, dated [redacted], in which the doctor stated that Appellant's father has uncontrolled diabetes with fluctuating blood sugars; low electrolyte levels with spontaneous onset, leading to sudden illness and hospitalizations; and uncontrolled sleep apnea. (Exhibit 4, page 8).

23. The doctor also concluded in that letter that, due to his medical conditions, Appellant's father is unable to be the primary caregiver for Appellant. (Exhibit 4, page 8).

24. [redacted], the Family Services Director for Community Living Services, Inc., reviewed the request for additional CLS and supporting documents. (Testimony of [redacted]).

25. In reviewing that request, [redacted] limited herself to reviewing Appellant's CLS, as that was the only additional services that were requested. (Testimony of [redacted].

26. Subsequently, she determined that the request and documentation failed to demonstrate a medical necessity for additional hours and that Appellant's current CLS could meet his needs. (Testimony of [redacted]

27. In making that determination, Plowden did not use Appellant's pending referral for HHS as a factor in either denying the request for additional CLS hours, on the basis that CLS can only complement HHS, or as a factor in approving the request, on the basis that CLS may be used for activities covered by HHS while the beneficiary awaits determination by DHS of the amount, scope and duration of HHS. (Testimony of [redacted]).

28. [redacted] also noted that if the approved services were proved to be insufficient and put too much of a strain on Appellant's natural supports, Appellant could always requested additional respite services as needed. (Testimony of [redacted]

29. On [redacted], Appellant's Personal Plan was amended to reflect that the request for [redacted] hours per day of CLS when Appellant is in school and [redacted] hours per day when out for [redacted] consecutive days, had been denied and that his CLS would continue at the previous amount of [redacted] hours per day of CLS when Appellant was in school and [redacted] hours per day when he was out of school for [redacted] consecutive days. (Exhibit 2, page 6).

30. On [redacted] Community Living Services, Inc. sent Appellant written notice that the request for additional CLS was denied. (Exhibit 2, page 7).

31. With respect to the reason for the denial, the notice stated that the documentation provided did not establish medical necessity for additional hours. (Exhibit A, pages 3-4).

32. On [redacted] mailed Appellant a copy of the finalized personal plan. (Exhibit A, page 45).

33. On [redacted], Community Living Services, Inc. completed a HHS referral for Appellant. (Exhibit 1, pages 1-12).

34. On [redacted] and Appellant's mother held a meeting, during which Appellant's mother indicated she was dissatisfied with the reduction in Appellant's services. (Exhibit A, page 74; Testimony of [redacted]

35. Appellant's mother also reported that Appellant's meltdowns/tantrums and incidences of inappropriate touching had increased since the transition. (Exhibit A, page 75).

36. [redacted] then informed Appellant's mother that there had been no reduction, but that Appellant's respite through the CWP had naturally expired and that Appellant was now only eligible for a lesser amount of respite through the HSW. (Exhibit A, page 74; Testimony of [redacted].

37. [redacted] also noted that Appellant's request for an increase in CLS staffing, to [redacted] hours per day when Appellant is in school and [redacted] hours per day when out for [redacted] consecutive days, had been denied. (Exhibit A, page 74).

38. Appellant's mother further reported that she had not heard back from DHS regarding HHS. (Exhibit A, page 74).

39. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this case.

40. On [redacted] MAHS sent out written notice of a telephone hearing scheduled for [redacted]

41. On [redacted], MAHS received a request from Appellant's representative that the hearing be held in-person.

42. On [redacted] MAHS sent out written notice of an in-person hearing scheduled for [redacted].

43. On [redacted], the in-person hearing was held as scheduled.

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*

Additionally, 42 CFR 430.10 states:

> 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 also 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 Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Here, as discussed above, Appellant has been receiving CLS and respite care services through the CMH and Community Living Services, Inc. at all times relevant to this action.

Prior to his [redacted] birthday, Appellant's services were authorized through the Children's Home and Community Based Services Waiver Program (CWP). With respect to the CWP, CLS and respite care services, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)**
>
> The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.
>
> The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.
>
> Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDCH must be submitted to the CWP Clinical Review Team at MDCH. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.
>
> **14.1 KEY PROVISIONS**
>
> The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.
>
> The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDCH to determine priority rating.

* * *

14.3 COVERED WAIVER SERVICES [CHANGES MADE 7/1/14]

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

Community Living Supports	Community Living Supports (CLS) provides assistance to a 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; 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. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided

	in school or other settings. Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications. The CMHSP must maintain the following documentation: ▪ A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan. ▪ Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family. All service costs must be maintained in the child's file for audit purposes.

* * *

Respite Care	Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with

	the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year. The cost of room and board cannot be included as part of 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, (revised 7/1/14)** nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions

	to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.

MPM, October 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 85-86, 90
(Internal highlighting omitted)

After his [redacted] birthday, Appellant's services have been authorized through the Habilitation Supports Waiver (HSW). With respect to the HSW, CLS and respite care services, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES [CHANGES MADE 7/1/14]**
>
> 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.
>
> HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:
>
> - Has a developmental disability (as defined by Michigan law);
> - Is Medicaid-eligible;
> - Is residing in a community setting;
> - If not for HSW services, would require ICF/IID level of care services; and

- Chooses to participate in the HSW in lieu of ICF/IID **(revised 7/1/14)** services.

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

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

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

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

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

15.1 WAIVER SUPPORTS AND SERVICES [CHANGE MADE 7/1/14]

Community Living Supports (CLS)	Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence

	(licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: ▪ Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: ➢ Meal Preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other

	necessities of daily living. ▪ Assistance, support and/or training the beneficiary with: ➢ Money management ➢ Non-medical care (not requiring nurse of physician intervention); ➢ Socialization and relationship building ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS 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/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 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 must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS 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 DHS 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	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, **(revised 7/1/14)** nursing facility, or hospital) or MDCH 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, October 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 96-98, 111-112
(Internal highlighting omitted)

While CLS and respite care are covered services through both the CWP and the HSW, beneficiaries are still only entitled to medically necessary services and the waivers did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM states:

> **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, October 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 12-14

In this case, it is undisputed that Appellant requires both CLS and respite care and it is only the amount of hours to be authorized that is at issue, with the CMH continuing to authorize [redacted] hours a day of CLS when Appellant is in school and [redacted] hours per day when he is out of school for [redacted] consecutive days, and Appellant requesting [redacted] hours per day of CLS when Appellant is in school and [redacted] hours per day when he is out of school for [redacted] consecutive days.

With respect to the request for additional CLS, [redacted], Appellant's case manager at Community Living Services, Inc., testified that, in discussing the transition from the CWP to the HSW, she informed Appellant's parents that Appellant would no longer be able to receive [redacted] hours per month of respite care services, which was the maximum allowed under the CWP, and would instead only be eligible for [redacted] per month of such services through the HSW. [redacted]t also testified that the change was not based on medical necessity and, instead, was based on what Community Living Services, Inc. typically offers through each program. [redacted] further testified that Appellant's mother than requested the additional CLS, and [redacted] initially put the additional hours in

Appellant's personal plan, in an attempt to keep Appellant's total services at approximately the same amount.

Appellant's mother testified that, when [redacted] informed her of the upcoming change in respite care services, Appellant's mother understood that change to be non-negotiable. She also testified that, as Appellant's needs and circumstances had not changed, she therefore requested additional CLS to make up for the reduction in respite care. According to Appellant's mother, the same staff provides Appellant's CLS and respite care, and she was not distinguishing between the two types of services in making her request. Instead, she was pursuing additional hours that would be necessary in light of the reduced respite care, Appellant's limited natural supports, and his unchanged needs. In support of that request, she also provided information regarding her difficulties in caring for Appellant alone, due to his size, and information regarding her job, where she is a flight attendant who works out-of-town for up to [redacted] days at a time, [redacted] to [redacted] times a month. Appellant's mother also provided a letter from Appellant's father's doctor in which that doctor described Appellant's father's medical conditions and concluded that, due to those conditions, Appellant's father is unable to be the primary caregiver for Appellant.

Appellant's request was denied and, according to [redacted] testimony, she based that decision on the specific request for more CLS that was before her and the specific documentation submitted in support of that request, which [redacted] felt did not demonstrate a medical necessity for more hours. [redacted]n also testified that, contrary to the position taken by Respondent's representatives, Appellant's pending application for HHS was not a factor in reviewing Appellant's request and that, instead, Plowden simply found that Appellant's current CLS were adequate. Similarly, [redacted] further testified that, while Appellant's respite care hours were significantly reduced during the transition to the HSW, despite the fact that Appellant's needs, including a need for [redacted] monitoring, had not changed, she was not trying to account for the reduced respite care hours or looking at the totality of Appellant's services in making her decision regarding CLS. In [redacted] opinion, to the extent that the reduced respite care services caused a greater strain on Appellant's natural supports and a need for intermittent relief, Appellant could always request additional respite care services in the future. However, no such request had been made and she therefore limited her assessment and decision to the specific request for additional CLS.

Appellant and his representative bear the ultimate burden of proving by a preponderance of the evidence that the CMH erred in denying the request for additional CLS hours, while the CMH also has the initial burden of going forward and demonstrating that its decision was in accordance with law and policy.

Here, while [redacted] properly noted that CLS and respite care are two distinct services with different purposes, it is disingenuous of Community Living Services, Inc. to fail to examine the totality of Appellant's services and the medical necessity for such services in this case, or to take into account the reduction in respite care, when addressing Appellant's request for additional CLS. Appellant was receiving a combination of respite

care and CLS through the CWP and, during the planning for the transition to the HSW, [redacted] informed Appellant's mother that respite care would be reduced, with Appellant's mother credibly testifying that she took that reduction to be non-negotiable and [redacted]t confirming that she expressly told Appellant's mother what the authorization of respite through the HSW would have to be. If Appellant wanted additional medically necessary services then, his mother understandably believed that she had no choice but to request additional CLS and not respite care. That is what she did and for Respondent to now limit itself solely to reviewing Appellant's CLS and to expressly decline to address or consider Appellant's respite care or the medical necessity for the combination of hours at all, while also claiming that Appellant can always request additional respite care in the future, is an error when Community Living Services, Inc. essentially dictated that Appellant could only request additional CLS at the plan meeting.

Moreover, the undersigned Administrative Law Judge also finds that Respondent erred in characterizing Appellant's request as being more appropriate for additional respite care. As properly noted by [redacted], respite care services through the HSW are provided to a beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregivers from daily stress and care demands during times when they are providing unpaid care. However, that is not what Appellant and his family are seeking in this case. They did not want intermittent relief; they wanted a plan in place that would provide all medically necessary services in light of Appellant's need for assistance, the limitations of his natural supports, and the other services he was receiving. Moreover, that request for additional assistance was for the purpose of preserving the health and safety of Appellant so that he could reside in the family home, which is a goal of CLS and not respite care.

The facts themselves in this case are largely undisputed and, given those facts, the errors discussed above and the applicable policies, the undersigned Administrative Law Judge further concludes that Respondent erred in denying Appellant's request and that at least some of the requested additional CLS hours should have been granted. Appellant's needs had not changed, but his circumstances have and those changed circumstances, including a significant reduction in respite care and additional information provided regarding limitations in Appellant's parents' ability or availability to provide care, demonstrated a medical necessity for additional CLS. Accordingly, the undersigned Administrative Law Judge finds that Respondent's decision must be reversed and that a reassessment should be performed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly denied Appellant's request for additional CLS.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED** and it must initiate a reassessment of Appellant's request for additional CLS.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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.