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

IN THE MATTER OF:

[redacted]

Docket No. 15-003053 CMH
Case No. [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], Appellant's father and power of attorney, appeared and testified on Appellant's behalf. [redacted], Appellant's independent supports coordinator, also testified on Appellant's behalf. [redacted], Corporation Counsel, represented Respondent [redacted] County Community Mental Health Authority [redacted], Assistant Director of Community Supports at Community Living Services of [redacted] County (CLS-[redacted]); [redacted], Manager of Provider Contracts at [redacted] A; and [redacted], Chief Financial Officer at [redacted]; testified as witnesses for the Respondent. [redacted], Manager of Due Process at [redacted], Assistant Due Process Manager at [redacted]; and [redacted], Self-Determination Coordinator at CLS-[redacted] were also present during the hearing.

Following the completion of the hearing, the undersigned Administrative Law Judge left the record open one week, until [redacted], at the request of Respondent's representative so that the parties could submit closing briefs.

ISSUE

Did [redacted] 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 is a [redacted] Medicaid beneficiary who has been diagnosed with Asperger's Syndrome; Pervasive Developmental Disorder, not otherwise specified; Obsessive-Compulsive Disorder (OCD); and Bipolar Disorder. (Exhibit A, page 8; Exhibit B, page 2).

2. Appellant lives in a private residence with his father/representative, who is his sole natural support, and attends [redacted] Schools [redacted] Post-Secondary Education Program. (Exhibit A, pages 33-34; Testimony of Appellant's representative).

3. Appellant receives [redacted] hours and [redacted] minutes of Home Help Services (HHS), with a total monthly care cost of [redacted], for assistance with bathing, grooming, dressing, toileting, eating, taking medications, housework, laundry, shopping, and meal preparation. (Exhibit 2, page 1).

4. Appellant's father/representative is his home help provider. (Exhibit 2, page 1).

5. Appellant has also been receiving services through [redacted] and CLS-[redacted], including supports coordination, medication reviews, fiscal intermediary services, non-emergency transportation, respite care services, and CLS. (Exhibit A, page 27).

6. When his current Individual Plan of Service (IPOS) was first authorized, on [redacted], Appellant was approved for [redacted] hours per month of respite care services and [redacted] hours per month of CLS through CLS-[redacted]s self-determination program. (Exhibit A, page 27).

7. However, during the development of that IPOS, Appellant and his representative had requested that an additional [redacted] hours per month of CLS be approved. (Exhibit B, page 2).

8. On [redacted] CLS-[redacted] sent Appellant written notice that the request for additional CLS was denied on the basis that CLS[redacted] and [redacted]A had made a utilization management decision to provide no more than [redacted] hours support services per day for single living situations unless there is a documented clinical rationale for an individual to live alone with [redacted] support staff. (Exhibit B, pages 2-3).

9. On [redacted] Appellant and his representative filed a request for hearing with the Michigan Administrative Hearing System (MAHS) with respect to the denial of additional CLS. (Exhibit B, page 3).

10. On [redacted] an administrative hearing was held. (Exhibit B, page 1).

11. On [redacted], the undersigned Administrative Law Judge issued a Decision and Order reversing the Respondent's decision and ordering it to initiate a reassessment of Appellant's request for additional CLS. (Exhibit B, pages 1-18).

12. On [redacted] following the receipt of the Decision and Order, a meeting was held between the parties during which Appellant's case was discussed, and additional evidence was requested from Appellant's representative. (Exhibit A, pages 29-32).

13. No decision on services was made at that time. (Exhibit A, pages 29-30).

14. At or after that meeting, Appellant and his representative amended their request for additional CLS and only asked for an additional [redacted] hours per month of CLS. (Testimony of [redacted]).

15. In making the request, Appellant's representative stated that he could continue to provide [redacted] hours per week of natural/informal supports and that the additional CLS would replace the additional approximately [redacted] hours per week of additional supports that he was previously providing, but was no longer able to. (Petitioner's Exhibit 3, page 1; Testimony of Appellant's representative; Testimony of [redacted]

16. The intent behind the request was to continue to keep at least one person with Appellant at all times despite the decreased natural supports. (Petitioner's Exhibit 3, page 1; Testimony of Appellant's representative; Testimony of [redacted].

17. On [redacted], CLS-[redacted] sent Appellant written notices stating that, based on the [redacted] meeting, it had been determined that his current authorizations needed to be adjusted, and that his CLS were therefore being increased from [redacted] hours per month to [redacted] hours per month while his respite care was being reduced from [redacted] hours per month to [redacted] hours per month. (Exhibit A, pages 2-3, 6-7).

18. Overall, Appellant's total hours of CLS and respite care would remain the same. (Exhibit A, pages 2-3, 6-7).

19. That same day, CLS[redacted] also sent Appellant written notice that the request for additional CLS was denied. (Exhibit 1, pages 2-3; Exhibit A, pages 4-5).

20. That notice provided in the pertinent part:

> You are being notified of your Due Process Rights pertaining to the request you made on [redacted] for an increase of [redacted] hours of Community Living Supports a month. Your request for an increase has been denied. Your current authorization of [redacted] hours of community living supports per month and [redacted]

> hours of respite per month will continued as authorized. Community Living Services of [redacted] County and [redacted] County Community Mental Health have made a Utilization Management decision to only provide supports at a level that would be required in a shared living situation, unless there is documented clinical rationale and mutual determination of medical necessity for an individual to live alone with one-to-one support staff; this is not the case in your situation. Your current authorization [redacted] hours of community living supports per month and [redacted] hours of respite per month has been clinically determined to be appropriate in amount, scope, and duration to implement your Individual Plan of Service.

Exhibit 1, page 2

21. According to [redacted], Appellant's services were reallocated to best match the goals of Appellant's IPOS while his request for an additional 1[redacted] hours of CLS was denied because his total hours were already sufficient to implement those goals. (Exhibit A, page 9; Testimony of [redacted]).

22. The goals in the IPOS at the time of the review continued to include goals relating to community inclusion and participation; completing daily chores and activities of daily living; managing symptoms of OCD and Bipolar disorder by practicing appropriate coping skills; and maintaining a healthy environment with strong family support, allowing Appellant to stay happy living at home. (Exhibit A, pages 8-13).

23. Specifically, with respect to the goal of managing Appellant's symptoms of OCD and Bipolar disorder, the IPOS stated that Appellant's symptoms included manic episodes that disturb sleep and Appellant requires [redacted] assistance from staff or his father in helping to manage those episodes. (Exhibit A, page 12).

24. Appellant's IPOS also generally noted that Appellant is never left unsupervised in community due to his elopement issues and that he needs to be monitored during all hours when awake for safety reasons, but he is able to be alone in his bedroom for up to [redacted] minutes at a time. (Exhibit A, page 19).

25. The IPOS further noted that Appellant has a tendency to wake up during the night and needs verbal prompting and soothing to get back to sleep,

and that he also has manic episodes causing him not to sleep well and during which staffing support of supervision is required. (Exhibit A, page 19).

26. At no point did [redacted], or anyone else at CLS-[redacted] or [redacted], specifically determine what level of supports would be required for Appellant in a shared living arrangement. (Testimony of [redacted].

27. [redacted] did not make such any such determination or pursue the possibility of a shared living arrangement further because Appellant's representative had no interest in a shared living arrangement for Appellant. (Testimony of [redacted]).

28. In general, however, the costs for services go down in a shared living arrangement. (Exhibit C, pages 1-2; Testimony of [redacted]).

29. The reallocation of hours between CLS and respite care took effect on [redacted] (Exhibit A, page 27).

30. Appellant's representative does not object to that reallocation, but still wants additional CLS. (Testimony of Appellant's representative; Testimony of [redacted]

31. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the denial of additional CLS. (Exhibit 1, pages 1-3).

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

33. On [redacted], Appellant's representative requested that the hearing be held in-person.

34. On [redacted] the matter was rescheduled as an in-person hearing on [redacted]

35. On [redacted] Respondent requested that the hearing be rescheduled for another date because witnesses necessary for the hearing were unavailable on [redacted].

36. On [redacted], the undersigned Administrative Law Judge issued an order granting the request to reschedule and the matter was rescheduled for [redacted]

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

38. Following the completion of the hearing, the undersigned Administrative Law Judge left the record open one week, until [redacted] at the

request of Respondent's representative so that the parties could submit closing briefs.

39. Respondent subsequently submitted a closing brief.

40. Appellant did not submit a closing brief.

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 Health and Human Services (DHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided pursuant to that waiver are CLS and respite care services. With respect to those services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
>
> - laundry

- routine, seasonal, and heavy household care and maintenance

- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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.

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.

* * *

17.3.I RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

MPM, January 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 122-123, 132-134

However, while both CLS and respite care are covered services, Medicaid beneficiaries are still only entitled to medically necessary services as the waiver 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, January 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 12-14*

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS and respite care services:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.
>
> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
>
> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive

environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to 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.

* * *

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.
>
> *MPM, January 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 119-120*

Here, Appellant was receiving [redacted] hours per month of respite care services and [redacted] hours per month of CLS through CLS-[redacted]'s self-determination program when, in [redacted] of [redacted] he requested an additional 1[redacted] hours per month of CLS. That request was denied on the basis that CLS-[redacted] would provide no more than [redacted] hours support services per day for single living situations unless there is a documented clinical rationale for an individual to live alone with [redacted] support staff. Appellant requested a hearing with request to that denial and, after holding a hearing, the undersigned Administrative Law Judge ordered that the denial be reversed and that the request for additional services be reassessed.

Subsequently, [redacted] and CLS-[redacted] decided to reallocate Appellant's CLS and respite care hours, while keeping his total hours the same, and Appellant amended his request to only ask for an additional [redacted] hours per month of CLS. [redacted] and CLS-[redacted] then denied the amended request.

In support of that decision, [redacted] the Assistant Director of Community Supports at CLS-[redacted], testified that, while she acknowledges that Appellant needs supports [redacted] hours a day, [redacted] days, a week, the hours authorized in Appellant's current IPOS are sufficient to address his two goals relating to assistance with community inclusion/participation and activities of daily living. [redacted] also testified that the denial of additional hours was based on the utilization management decision to only provide supports at the level that would be required in a shared living situation, unless there is documented clinical rationale and mutual determination of medical necessity for an individual to live alone with [redacted] support staff. According to [redacted] Appellant does not require [redacted] support staff given his needs, lack of hospitalizations and lack of conflict with other recipients, and he could therefore live in shared living arrangement. In such a shared living arrangement, Appellant could receive both shared and unshared hours, but [redacted] could not say at this time what any specific arrangement would look like or what his level of services would be. She did not pursue such an arrangement, even on a temporary basis, because Appellant and his representative were not interested.

[redacted], Chief Financial Officer at [redacted], testified regarding the amount of consumers served by [redacted] and the fact that it is both running a deficit currently and expecting fewer funds in the future. She also testified that, due to its lesser cost, there is a general shift toward paying a per diem rate for services and that the average per diem rate is [redacted] per day, with adjustments made as needed in specific cases. She further testified that care costs can be reduced further in shared living arrangements, where the per diem rate can be split among beneficiaries, and that costs go down the more consumers that share the services.

[redacted], Manager of Provider Contracts at [redacted] testified that, when a consumer receives [redacted] or more hours of services per day, [redacted] will generally look at using a per diem rate, though the hours could be more or less depending on the circumstances. She also discussed [redacted]'s Policy Number CL [redacted] which she supervised the drafting of and believes is in conformance with the provisions of the MPM. That policy provides in part that:

> III. The mental health system is not responsible to provide one-on-one supports to an individual on a [redacted] basis unless there is a clinically supported documentation for why a person must live alone with this level of support. The mental health system is responsible to assure appropriate services and supports are provided to all persons eligible for public mental health services. For individuals [redacted] and older who need to make decisions about living situation, it will be necessary to explore the following options:
>
> 1. Living with family – There is an expectation that some level of natural supports will be provided in this situation.

2. Living with a room-mate(s) – There is an expectation that individuals are provided a choice of location and room-mate(s). Affordability of the living situation and the ability to share staffing supports are also expected. Living with room-mates can occur in both unlicensed and licensed settings.
3. Living alone – All people have the right to live alone if they choose. However, the mental health system does not have an obligation to provide for all support needs if there are other options available that are more cost effective and meet the person's support needs. If an individual chooses to live alone, the mental health system will only provide supports at the level it would be required to in a shared living situation that meets the individual's needs. All other needs must be met via natural supports or the individual's personal financial resources.

Exhibit D, page 3

[redacted] further testified that, in applying the above policy, the case worker must determine what the level of supports in a shared living arrangement would be for the individual consumer as amounts may vary depending on the individual's needs. She had no clinical knowledge of this case and did not know if any such individualized determination was made here, but she also testified that the previous notice of denial, which identified a general limit of [redacted] hours per day, had been sent in error as there was no such preset limit.

In response, [redacted], Appellant's independent supports coordinator, testified that Appellant's representative understood the reallocation of hours and was also willing to amend the request to reflect Appellant's representative's willingness to provide [redacted] hours per week of natural supports, but that he still wanted additional CLS hours because Appellant required [redacted] assistance [redacted], whether it be from natural supports, CLS, respite care, HHS, the school or Appellant's summer camp. In particular, [redacted] testified that, as stated in Appellant's plan, Appellant requires support during the night when he wakes up or has a manic episode, and there is no way to predict when that will occur. [redacted] also testified that Appellant's services were not provided at a per diem rate right now, but that he would guess that Appellant's per diem rate would be higher than average given his needs. [redacted] further testified that he did not believe Appellant could receive services at a [redacted] ratio given Appellant's school's determination that Appellant needed [redacted] services there, Appellant's past issues during group tasks, and the lack of any documented rationale that he could succeed [redacted] Moreover, he also believed that the information relied upon by [redacted], such as a lack of hospitalizations for Appellant, only existed because of the excellent [redacted] care that Appellant has been receiving.

Appellant's father/representative also testified that, due to Appellant's mental health issues, including Asperger's Syndrome, OCD, fluctuating manic depression, sleep problems, elopement and a seizure disorder, Appellant requires [redacted] support [redacted] hours a day, [redacted] days a week. Appellant's representative also testified that, as Appellant's sole natural support, he is currently filling in any gaps in the services Appellant receives, but that he and Appellant require additional services in order to maintain Appellant safely in the home. Appellant's representative further testified that both the staff at Appellant's school and Appellant's CLS workers have advised him that Appellant needs [redacted] support. Appellant's representative also stated that he has tried to work with CLS [redacted] to develop other options or arrangements without success.

Appellant bears the burden of proving by a preponderance of the evidence that [redacted] erred in denying the request for additional CLS and that he is entitled to the services while Respondent bears the initial burden of going forward with sufficient evidence to show that its action is correct and in accordance with law and policy.

Here, the undersigned Administrative Law Judge finds that Appellant has met his burden of proof and the decision regarding the denial of additional CLS must therefore be reversed and Appellant's request must be granted.

Coverage through CLS can include staff assistance with preserving the health and safety of an individual in order that he may reside or be supported in the most integrated, independent community setting and that goal of CLS is reflected in Appellant's IPOS. For example, while [redacted] only identified goals relating to community inclusion/participation and completion of activities of daily living, the IPOS also contains goals relating to Appellant managing the symptoms of his OCD and Bipolar disorder by practicing appropriate coping skills and maintaining a healthy environment with strong family support in order to allow Appellant to stay happy living at home. Moreover, the IPOS also specifically notes that his staff provides [redacted] assistance in managing Appellant's symptoms, including his nighttime manic episodes, and monitoring Appellant during all the hours he is awake for safety reasons.

It is undisputed that Appellant needs supports [redacted] hours a day, [redacted] days week and that his needs are currently by met on a [redacted] basis through a combination of natural supports, CLS, respite care, HHS, his school, and Appellant's summer camp. Moreover, it is also undisputed that there will be a decrease in the informal supports that Appellant's father is providing and that the requested additional CLS would fill in the gaps left in the [redacted] services dues to the decrease in Appellant's natural supports.

Given Appellant's needs and decreased natural supports, in addition to the goals specifically outlined in his IPOS, Appellant has therefore demonstrated a medical necessity for the additional CLS services that were requested.

Respondent argues that, even if the additional services are found to be medically necessary to maintain Appellant's current living situation, Appellant does not need to live alone and the request for additional services should therefore be denied pursuant to

its policy that, if an individual chooses to live alone, the mental health system will only provide supports at the level it would be required to in a shared living situation that meets the individual's needs.

However, Respondent relies on that policy without identifying what the limit on services is in this case, *i.e.* the level of supports that would meet Appellant's needs in a shared living situation. Respondent cannot deny the request for additional services based on a policy that his services are limited to a certain level without determining what that level is and evidence that it is generally more cost-effective to provide support services in a shared living arrangement, as opposed to a single person setting, is insufficient to justify a specific limit in this case.

[redacted] testified that she did not determine what level of supports would be required for Appellant in a shared living arrangement because Appellant's representative had no interest in a shared living arrangement for Appellant and that it would be unworkable to try to proceed in those circumstances. Respondent's representative also argued that it would impossible to do an exact cost comparison of single service versus a shared arrangement when the client is not open to the arrangement.

However, that is clearly what the plain language of [redacted]'s policy provides as supports are limited to the level that would be required to meet the specific individual's needs.

Similarly, that is exactly what [redacted], who supervised the drafting of the policy, testified is required in all cases as the level of supports in a shared living arrangement for an individual consumer will vary depending on the individual's needs.

Moreover, making an individualized determination would be required to bring [redacted]s policy in conformance with the MPM. In authorizing[redacted] services, such as CLS, [redacted] "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." MPM, January 1, 2015 version, Mental Health/Substance Abuse Chapter, page 120. However, the MPM also provides that "[a] PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services" and "determination of the need for services shall be conducted on an individualized basis". MPM, January 1, 2015 version, Mental Health/Substance Abuse Chapter, page 14.

That is what Respondent did in this case by denying additional services on the basis of a general, but unidentified, preset limit on services. Its decision is essentially no different from the earlier decision, which was reversed on appeal and which Respondent now acknowledges was improper, to cap services in this case to [redacted] hours a day in a single living arrangement. In neither case was an individualized assessment done on Appellant's needs and an arbitrary limit placed on services, whether it is [redacted] hours a day or some unidentified limit. If Respondent wants to limit services in this case to a specific level pursuant to the policy requiring it to take its capacity to

reasonable and equitably serve other beneficiaries in need, then it needs to determine and identify what the specific level is in this case.

Accordingly, in light of the evidence regarding Appellant's decreased natural supports, but continuing medical need for [redacted]k supports reflected in his IPOS, in addition to Respondent's failure to apply its own policy correctly or justify a limit on medically necessary services, the undersigned Administrative Law Judge finds that Respondent's decision must be reversed and Appellant's request for additional CLS hours must be granted.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

Respondent's decision is **REVERSED** and it must initiate an approval of Appellant's request for additional CLS.

Steven Kibit

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

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.