



STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[REDACTED]
[REDACTED]
MI [REDACTED]

Date Mailed: July 9, 2024
MOAHR Docket No.: 24-004607
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

The above-captioned matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed by Petitioner [REDACTED] (Petitioner).

After due notice, a hearing via video conferencing was held on June 26, 2024. [REDACTED] Petitioner's mother, appeared and testified on Petitioner's behalf. [REDACTED] Petitioner's father, also testified as a witness for Petitioner. Stacy Coleman, Contractor, appeared and testified on behalf of Respondent Macomb County Mental Health (Respondent).

During the hearing, the following exhibits were entered into the record:

Petitioner's Exhibit:

Exhibit #1: Request for Hearing

Respondent's Exhibits:

Exhibit A: Individual Plan of Services

Exhibit B: Notice of Adverse Benefit Determination

Exhibit C: Notice of Appeal Denial

ISSUE

Did Respondent properly deny Petitioner's request for goods and services?

FINDINGS OF FACT

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

1. Petitioner is a [REDACTED] year-old Medicaid beneficiary who has been diagnosed with, among other conditions, an intellectual developmental disorder, a language disorder, autism spectrum disorder, an immune system disorder, anxiety, obsessive-compulsive disorder, separation disorder, and post-traumatic stress disorder. (Exhibit A, pages 1, 27).
2. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Respondent pursuant to Michigan's Habilitation Supports Waiver (HSW). (Exhibit #1, page 1).
3. Through the HSW, Petitioner has opted to use self-determination and manage his own individual budget. (Exhibit #1, page 1).
4. His specific services have included targeted case management, community living supports (CLS), respite care services, enhanced pharmacy, overnight health and safety services, home care training, fiscal intermediary services, and goods and services. (Testimony of Petitioner's representative; Testimony of Respondent's representative).
5. His goods and services included membership at [REDACTED] and [REDACTED] years ago, but they are not currently authorized. (Testimony of Petitioner's representative).
6. As part of Petitioner's Individual Plan of Service (IPOS) for the period of June 1, 2023 through July 31, 2024, Petitioner again requested that membership at [REDACTED] and [REDACTED] be provided as part of his goods and services. (Exhibit A, page 24-25).
7. However, that request was denied. (Testimony of Petitioner's representative; Testimony of Respondent's representative).
8. Petitioner did not request an Internal Appeal with Respondent at the time of that denial. (Testimony of Petitioner's representative; Testimony of Respondent's representative).
9. In February of 2024, Petitioner again requested that goods and services be authorized for membership at [REDACTED] and [REDACTED] as part of an IPOS Addendum. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

10. The request was submitted by Petitioner's supports coordinator, who indicated that, as stated in the initial IPOS, Petitioner's CLS workers would assist Petitioner at [REDACTED] and [REDACTED] (Exhibit A, pages 24-25; Testimony of Respondent's representative).
11. Petitioner and his representative did not sign the plan IPOS Addendum because it indicated that the CLS would be necessary and would always assist him instead of stating that they may assist him. (Testimony of Petitioner's representative).
12. On February 5, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that his request for goods and services had been denied because, based on a review of the documentation in the medical record, authorization of the services did not meet the criteria found in the Medicaid Provider Manual. (Exhibit B, pages 1-7).
13. Petitioner then requested an Internal Appeal with Respondent regarding that decision. (Exhibit C, page 1).
14. On April 20, 2024, Respondent sent Petitioner a Notice of Appeal Denial stating that the decision to deny his request for goods and services was being upheld. (Exhibit C, pages 1-6).
15. With respect to the reason for the decision, the Notice of Appeal Denial stated in part:

In the Medicaid Provider Manual (MPM), Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or covered State Plan definitions) to the extent that individual budget expenditures would otherwise be made for human assistance. The IPOS addendum says that he will go to both the [REDACTED] and [REDACTED] with help from CLS staff and that his staff will be onsite with him while there to work on his Community Living Support (CLS) objectives. The budget expenditures will be for the [REDACTED] tuition, the [REDACTED] membership fees, and the CLS staffing for the time he is present at either location. This is not in line the MPM definition and scope of Goods and Services. of this service.

16. On April 30, 2024, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the decision to deny his request for goods and services. (Exhibit #1, pages 1-8).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other

than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

42 USC 1396n(b)

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner is approved for services through Respondent through Michigan's Habilitation Supports Waiver (HSW) and, pursuant to that program, he has requested specific goods and services.

With respect to the HSW in general, and goods and service through it specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan 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 their individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS 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 services.

The PIHP's 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, does not receive at least one HSW habilitative service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and Community Based 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.

* * *

<p>Goods and Services</p>	<p>The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using self-directed services and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. <i>Goods and services must</i></p>
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	<p><u>increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or covered State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.</u></p> <p>A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.</p> <p>Goods and Services are available only to individuals who self direct their services whose individual budget is lodged with a fiscal intermediary.</p> <p>This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.</p>
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*MPM, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 123, 130
(emphasis added)*

Here, as discussed above, Petitioner has requested goods and services through Respondent pursuant to the HSW; Respondent denied that request; and Petitioner has appealed Respondent's decision.

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

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed.

It is undisputed that Petitioner was approved for the requested goods and services years ago, but that past approval is not dispositive, and it is also undisputed that Respondent has, more recently than any approval, denied the specific goods and services requested. Moreover, the probative value of any past approval is limited here given that there is nothing in the record as to what specifically was authorized, how the services were authorized or provided, or why they ended.

Similarly, the undersigned ALJ gives limited weight to Petitioner's representative's arguments that Respondent's decision was based on improper grounds, such as retaliation or Respondent's representative having financial incentives to deny Internal Appeals. The parties appear to have had a contentious relationship over the years and, on at least a short-term basis, Respondent's representative would appear to get more work as a contractor with Respondent if matters proceeded to a State Fair hearing, but Petitioner's arguments are otherwise unsupported and the basis for Respondent's decision was consistently identified in the Notice of Appeal Decision and the hearing itself.

Specifically, Respondent denied Petitioner's request on the basis that the requested goods and services were not a "substitute for human assistance . . . to the extent that individual budget expenditures would otherwise be made for the human assistance" as required by the MPM. *See MPM, January 1, 2024 version Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 130.*

Moreover, given the record in this case, Respondent's decision was correct. Even accepting Petitioner's representative's testimony that Petitioner's IPOS Addendum should have said that Petitioner's CLS workers or natural supports may assist him in utilizing the goods and services, as opposed to saying that CLS workers were necessary, Petitioner's request still does not meet applicable criteria. Petitioner's request is for goods and services in addition to what he is already receiving and there is simply no suggestion that, as expressly required by policy, they would be a substitute for human assistance, such as his community living supports, to the extent that individual budget expenditures would otherwise have been made for such human assistance or that his individual budget would be altered to account for such a substitution if the goods and services were approved.

Accordingly, while Petitioner disputes the applicable policy, the undersigned ALJ finds that the policy is clear; both Respondent and the ALJ are bound by it; and Respondent's decision must therefore be affirmed as the requested goods and services do not meet the criteria found in that policy.

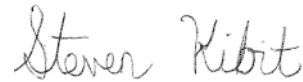
DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's request for goods and services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

SK/sj



Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 9th day of July 2024.

S. James

S. James
**Michigan Office of Administrative
Hearings and Rules**

Via Electronic Mail & First Class Mail:

Petitioner

[REDACTED]
[REDACTED] MI [REDACTED]
[REDACTED]

Authorized Hearing Representative

[REDACTED]
[REDACTED] MI [REDACTED]
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Authorized Hearing Representative

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