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Date Mailed: May 6, 2021
MOAHR Docket No.: 20-007991; 20-000501
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

These matters are before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's requests for hearing.

On December 23, 2020, Petitioner filed an Emergency Motion to Reinstate and Continue Benefits Pending Appeal, which was assigned docket number 20-007991. On February 17, 2021, a telephone prehearing conference was held, and a hearing was scheduled for March 24, 2021. At the prehearing conference, the undersigned took Petitioner's motion under advisement. On February 23, 2021, an Order was issued regarding Petitioner's Motion, which partially granted Petitioner the relief he sought.

On February 17, 2021, Petitioner filed a request for hearing challenging Respondent's underlying authorization of services, which was assigned docket number 21-000501. This docket number was consolidated with docket number 20-007991 for hearing purposes and scheduled for hearing on March 24, 2021. The March 24, 2021 hearing was adjourned per Petitioner's request and rescheduled for May 4, 2021. The May 4, 2021 hearing proceeded as scheduled.

Attorney and Guardian [redacted] appeared on behalf of Petitioner, [redacted] (Petitioner). [redacted] Petitioner's mother, appeared as a witness for Petitioner.

Jackie Bradley, Fair Hearing Officer, appeared on behalf of Respondent, Lenawee Community Mental Health Authority (Respondent, CMH, or LCMHA). Holly Owen, Chief Operating Officer and Interim IDD Program Director, appeared as a witness for Respondent.

ISSUE

Did the CMH properly authorize Petitioner's Community Living Supports (CLS) under the Habilitation Supports Waiver (HSW) upon his move from Washtenaw County to Lenawee County?

EXHIBITS

Petitioner's Exhibits: 1-17

Respondent's Exhibits: A-K

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, born April 11, 1998. (Exhibit 3, p 1; Testimony)

2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area.

3. Petitioner began receiving services through [redacted] County Community Mental Health (WCCMH) in 2014 through the Children's Waiver Program when he resided in Washtenaw County. (Exhibit 3; Testimony)

4. On July 27, 2020, WCCMH held a person-centered planning meeting and an IPOS was developed. By that time Petitioner was receiving services under the Habilitation Supports Waiver and was authorized to receive 119 hours per week of CLS (17 hours per day) and 208 hours of respite per year (4 hours per week). (Exhibit 3; Testimony)

5. Petitioner was and is currently also authorized to receive 142 hours and 28 minutes per month of Adult Home Help (AHH) through MDHHS, which is an average of 4.75 hours per day in a 30-day month. (Exhibit 4; Testimony)

6. On October 22, 2020, in anticipation of an upcoming move from [redacted] County to [redacted] County, an intake appointment was completed with LCMHA. As part of this process, Petitioner's Guardian and Mother both informed LCMHA that Petitioner was a current recipient of services through WCCMH and asked that his services be transferred. LCMHA completed a Bio/Psycho/Social Assessment of Petitioner as part of the intake process. (Exhibits 5, I; Testimony).

7. WCCMH and LCMHA are both part of the same Prepaid Inpatient Health Plan (PIHP), Community Mental Health Partnership of Southeast, Michigan (CMHPSM). A PIHP is an organization that is responsible for managing Medicaid services related to behavioral health and developmental disabilities. According to CMHPSM's website, its intention is to "ensure consistent implementation and management of services provided." (See www.cmhpsm.org)

8. On October 26, 2020, Petitioner and his family moved to a new home in [redacted] County, Michigan and, on that same date, WCCMH issued a Notice of Adverse Benefit Determination closing Petitioner's case, effective December 1, 2020. (Exhibit 6; Testimony)

9. On November 20, 2020, LCMHA completed a CLS Assessment for Petitioner. (Exhibits 12, J; Testimony)

10. On December 10, 2020, a person-centered planning meeting was held with Petitioner, his LCMHA Case Manager, his Guardian and his Mother. (Exhibits 1, K; Testimony)

11. On December 18, 2020, LCMHA created Petitioner's Individualized Plan of Service (IPOS), authorizing 11.5 hours per day of CLS, effective December 23, 2020, or 5.5 hours less per day than what had been authorized by WCCMH. (Exhibit 7, pp 6-7; Exhibit K; Testimony)

12. The CLS authorization approved by LCMHA does not match up with its own CLS assessment for Petitioner. The CLS assessment indicates that Petitioner requires 17.83 hours of unspecified paid caregiving per day. If one subtracts the 4.75 hours of AHH Petitioner receives per day from 17.83, that equals 13.08 hours of care per day. Given that Petitioner is not authorized for any other paid caregiving, that would mean Petitioner should be authorized for 13.08 hours of CLS per day. Again, LCMHA only authorized 11.5 CLS hours per day. (Exhibit 12; Testimony)

13. LCMHA did not meet MDHHS guidelines for timeliness when authorizing Petitioner's CLS. (See MCL 330.1712, MPM Section 2.1, and PIHP Policy and Procedures.) The period between Petitioner's initial intake with LCMHA (October 22, 2020) and LCMHA's authorization of Petitioner's services was 2 months, 1 day, or 8 weeks 6 days, or 62 calendar days. Guidelines indicate this process should have taken 14 days.

14. On December 23, 2020, Petitioner's Guardian faxed a Request for an Expedited Local Appeal to Respondent. (Exhibit 8; Testimony). Respondent denied the request for an expedited appeal on that same date. (Exhibits 9, C; Testimony)

15. On February 2, 2021, Respondent denied Petitioner's local appeal and

provided Petitioner with his appeal rights. (Exhibits 9, E; Testimony)

16. Petitioner is diagnosed with spastic quadriplegic cerebral palsy, severe cognitive impairments, neuromuscular scoliosis, Lennon-Gestaut Syndrome, tachycardia, dysphagia and restrictive lung disease. (Exhibits 3, 10; Testimony)

17. Petitioner is non-verbal, non-ambulatory and completely dependent on others for all activities of daily living. Petitioner is fed through a G-tube, he requires regular suctioning and repositioning, and he must be monitored for seizure activity that sometimes requires emergency medical intervention. Due to his conditions, Petitioner cannot be left alone and must be monitored for safety 24/7. (Exhibits 3, 7, 10; Testimony)

18. Petitioner lives with his Mother, who is also his primary caregiver. Petitioner has three brothers who were able to provide a significant amount of care for him in the past. However, the brothers are now adults, have their own families, and are not able to assist with Petitioner's care as much as in the past. (Exhibit 3; Testimony)

19. Prior to the COVID-19 pandemic, Petitioner had attended school at High Point in Ann Arbor. However, due to his fragile medical state, he has been unable to attend school since March 2020. (Exhibit 3; Testimony)

20. Petitioner's medical conditions have worsened as he has grown older, his care needs have increased, and his services have been increased over the years to accommodate. In February 2019, WCCMH increased Petitioner's CLS hours from 54 to 84 per week and then, in March 2020 when Petitioner could no longer attend school, to 114 hours per week. Petitioner's Adult Home Help increased from 134 hours and 58 minutes per month to 142 hours and 29 minutes per month on June 24, 2019. (Exhibit 4; Testimony)

21. Petitioner's requests for hearing were received in these consolidated matters on December 23, 2020 and February 17, 2021, respectively. (Exhibit 1)

CONCLUSIONS OF LAW

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

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are

> age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*
>
> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

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

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

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

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.
>
> **2.5.B. DETERMINATION CRITERIA**
>
> The determination of a medically necessary support, service or treatment must be:
>
> - Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
> - Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- 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; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:

- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
October 1, 2020, pp 12-14

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

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 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 MDHHS Bureau of 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.

15.1 WAIVER SUPPORTS AND SERVICES

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.
- Assisting, supporting and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs,

and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
October 1, 2020, pp 106-108

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

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

17.3.B. COMMUNITY LIVING SUPPORTS

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 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 is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator 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. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on 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 nonmedical 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 Personal Care services. 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
October 1, 2020, pp 131, 134-135
Emphasis added.

LCMHA's Interim IDD Program Director and Chief Operating Officer (LCMHA's COO) testified that she is a Licensed Master's Social Worker (LMSW) and has worked for LCMHA for 15 years. LCMHA's COO testified that she supervises the case manager assigned to Petitioner. In the instant case, LCMHA's COO indicated that she became familiar with Petitioner's case when it was forwarded to her for review as the IDD Program Director. LCMHA's COO indicated that she reviewed Petitioner's CLS assessment, his IPOS, the Medicaid Provider Manual and other records in the file and supported the decision to authorize 11.5 CLS hours per day for Petitioner. LCMHA's COO testified that in coming to her determination, she considered the uses of CLS, including CLS for health and safety, as well as the availability of informal supports. LCMHA's COO testified that during the internal appeal process a new letter from Petitioner's doctor was received, but the letter did not change her conclusion that the authorization of 11.5 CLS hours per day was proper. LCMHA's COO testified that there was no evidence that Petitioner could not meet the goals in his IPOS with 11.5 CLS hours per day.

On cross examination, LCMHA's COO testified that she has never met Petitioner, has not been to his home, and had no contact with Petitioner's Mother or Guardian prior to

December 23, 2020. LCMHA's COO indicated that she is aware that Petitioner is a quadriplegic, cannot talk and cannot be left alone. LCMHA's COO testified that she got involved in Petitioner's case after the intake was completed, which included the bio/psycho-social assessment. LCMHA's COO indicated that the assessment showed that Petitioner met the criteria for IDD services. LCMHA's COO reviewed the timelines found in MCL 333.1712 and admitted that LCMHA failed to meet those timelines in Petitioner's case. LCMHA's COO testified that CLS authorizations do not get transferred between counties, even within the same PIHP, and that part of the delay was because Petitioner has commercial (private) insurance also, that had to be verified.

LCMHA's COO testified that their position is that whatever hours during the day that are not covered by CLS or AHH must be covered by natural supports. LCMHA's COO testified that she was aware that Petitioner is incontinent and what that involves for Petitioner's care. LCMHA's COO indicated that no CLS hours were authorized to manage Petitioner's money because she assumed Petitioner's Guardian managed his money, although she admitted that she did not ask Petitioner's Mother or Guardian. LCMHA's COO admitted that no CLS hours were authorized for medication management even though Petitioner cannot order or administer his own medications as those medications are administered through Petitioner's G-tube.

LCMHA's COO also admitted that the CLS assessment was not provided to Petitioner's Guardian until the expedited request for an internal appeal was made on December 23, 2020. LCMHA's COO indicated that Petitioner's Guardian was not given an opportunity to have any input with the CLS assessment and the CLS assessment was not provided to Petitioner's Guardian or Mother at the IPOS meeting held on December 10, 2020. LCMHA's COO admitted that Petitioner's IPOS indicates in numerous places that Petitioner requires 24/7 care and monitoring.

LCMHA's COO reviewed with Petitioner's Guardian the significant number of tasks Petitioner's mother is expected to do as Petitioner's natural support in Petitioner's IPOS, including repositioning Petitioner every two hours and toileting as frequently as needed. LCMHA's COO also reviewed other tasks expected of Petitioner's mother as natural supports including scheduling medical appointments, providing transportation, accompanying Petitioner to doctor's appointments, monitoring medications, coordinating care, maintaining medical equipment, and coordinating medical equipment replacement with the insurance company. LCMHA's COO indicated that LCMHA does not have a formal written policy on natural supports.

LCMHA's COO testified that Petitioner was receiving four hours of respite per month at WCCMH and continues to receive four hours of respite per month at LCMHA, even though Petitioner's CLS hours have been reduced by 5.5 hours per day, resulting in more work for Petitioner's mother. LCMHA's COO also admitted that there was no respite assessment completed by LCMHA as part of Petitioner's intake or person-centered planning.

LCMHA's COO indicated that she does not think the PIHP's standards of reducing organizational barriers and continuity of care between agencies was necessarily met in

Petitioner's case as the IPOS and authorization could have been done quicker. LCMHA's COO noted that LCMHA does have a duty to work with other CMH agencies when a participant transfers in or out of LCMHA. LCMHA's COO indicated that when someone transfers in to LCMHA from another CMH, LCMHA requests records from the transferring agency and that LCMHA does help individuals when they transfer from LCMHA to another CMH agency.

Petitioner's mother testified that she is Petitioner's primary caregiver and has been his entire life. Petitioner's mother indicated that she and Petitioner's father divorced in 2009 but had been separated since 2008 and he has not provided any direct care to Petitioner since that time. Petitioner's mother indicated that Petitioner's brothers have helped with Petitioner's care over the years but are unable to do so now because they are adults and have their own lives, careers, and families. Petitioner's mother testified that she established a guardianship for Petitioner when he turned 18 and later switched the guardian from her to the current guardian when she got cancer in 2018 and worried what would happen to Petitioner if something happened to her. Petitioner's mother testified that she was still working, and Petitioner was still attending school then. Petitioner's mother testified that if was difficult to find caregivers at that time and she missed a lot of work and Petitioner missed a lot of school because of his medical issues.

Petitioner's mother testified that she eventually decided to quit her job and become Petitioner's caregiver full-time. Petitioner's mother indicated that Petitioner's brothers are no longer able to offer much direct care for Petitioner because they are adults now and have their own lives. Petitioner's mother testified that prior to the pandemic she had paid caregivers for Petitioner but due to his health conditions and risks she could not expose Petitioner to outside caregivers once the pandemic started. Petitioner's mother noted that Petitioner was also unable to get the COVID vaccine until the end of March 2021.

Petitioner's mother testified that Petitioner was in hospice in both 2014 and 2017 and that his health has deteriorated over the years. Petitioner's mother indicated that there was a time when Petitioner could feed himself, but no more. Petitioner's mother confirmed that Petitioner's supports have increased over the years as his needs have increased. Petitioner's mother testified that Petitioner is happy living at home with his family and is only alive because of the excellent care he has received. Petitioner's mother testified that she is able to provide the same amount of natural supports as she did when Petitioner received services through WCCMH.

On cross examination, Petitioner's mother testified that she was present during Petitioner's IPOS meeting, she is Petitioner's primary caregiver, and the IPOS is an accurate representation of Petitioner's goals and objectives. Petitioner's mother indicated that she participated in the development of Petitioner's goals and objectives in his current IPOS but that most of those goals and objectives were just carried over from Petitioner's IPOS at WCCMH. Petitioner's mother indicated that one thing she does disagree with on the current IPOS, which is different from the WCCMH IPOS, is that the current IPOS does not indicate on the first page Petitioner's health and safety concerns.

Petitioner's mother indicated that she is physically able to perform all the natural supports required of her in the current IPOS but is unwilling to perform that level of natural supports, especially since she was not made to do so when Petitioner lived in Washtenaw County. Petitioner's mother noted that the work she is being forced to do as a natural support is work considered CLS under the HSW and B-3 services. Petitioner's mother testified that when Petitioner is participating in recreational activities with Petitioner, she is still working because she must be interactive with him. Petitioner's mother explained that she must bring the world to Petitioner; he cannot experience it on his own. Petitioner's mother testified that she could not think of a time when she is just spending time with Petitioner when also not providing some care or monitoring. Petitioner's mother indicated that when Petitioner is awake, someone needs to be with him and when he is asleep, someone needs to monitor him, physically check on him, respond to changes in his oxygen levels and reposition him. Petitioner's mother testified that about two-thirds of the time Petitioner needs some sort of intervention when she checks on him.

Petitioner's mother testified that she did participate in the CLS assessment in November, but she did not agree with the clinician's conclusions. Petitioner's mother noted that the clinician kept saying everything was personal care (which would be covered by AHH), which she did not agree with. Petitioner's mother testified that the CLS assessment missed the fact that Petitioner needs his space cleaned, his trash removed, his medications picked up and his medications administered, among other things. Petitioner's mother testified that due to Petitioner's incontinence, his trash needs to be picked up and disposed of separately from the household trash. Petitioner's mother indicated that this occurs five to six times per day on average. Petitioner's mother testified that she has always expected and agreed to provide some care for Petitioner as a natural support since Petitioner and the family have chosen for Petitioner to reside in the family home, but she does not agree with the level of natural support LCMHA expects her to perform.

Petitioner bears the burden of proving by a preponderance of the evidence that CMH erred in authorizing Petitioner's CLS when he moved from [redacted] County to [redacted] County in October 2020. Based on the evidence presented, Petitioner has met this burden.

First, it must be mentioned that LCMHA's intake and authorization of Petitioner's services was wholly inadequate. As indicated above, the period between Petitioner's initial intake with LCMHA (October 22, 2020) and LCMHA's authorization of Petitioner's services (December 23, 2020) was 2 months, 1 day, or 8 weeks 6 days, or 62 calendar days. And this is for a beneficiary transferring between CMH's in the same PIHP, not a brand-new beneficiary off the street. As such, Respondent had easy access to all the clinical information from WCCMH and there is no excuse for such a delay. This delay fails to meet MDHHS' standards of promptness and, on its own, is grounds for a reversal of Respondent's authorization.

However, even if LCMHA had acted promptly, its authorization of CLS in Petitioner's case was improper. As indicated, when Petitioner received CLS through WCCMH, he

was authorized to receive 17 CLS hours per day. So, even as a practical matter, if Petitioner moves down the road to a new home covered by another CMH, and that CMH reduces his CLS by 5.5 hours per day (or by some 32%), that new CMH better have a solid justification for the decrease. Here, LCMHA offers no justification for the decrease and little support for the medical necessity of only 11.5 CLS hours per day.

Here, Petitioner's medical conditions have worsened as he has grown older, his care needs have increased, and his services have been increased over the years to accommodate. For example, in February 2019, WCCMH increased Petitioner's CLS hours from 54 to 84 per week and then, in March 2020 when Petitioner could no longer attend school, to 114 hours per week. Petitioner's Adult Home Help also increased from 134 hours and 58 minutes per month to 142 hours and 29 minutes per month on June 24, 2019. As such, LCMHA's CLS authorization here makes even less sense.

As indicated above, under the MPM, HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. As such, Petitioner is entitled to CLS for staff assistance with preserving his health and safety, as outlined in Section 17.3.B of the MPM. The parties agree that Petitioner requires 24/7 care and monitoring so any supports that are not paid for by Medicaid fall to Petitioner's mother. As indicated above in MPM Section 17.2, natural supports mean unpaid assistance provided by people who are willing and able to provide that service. Here, while Petitioner's mother may be physically able to make up the additional 5.5 hours per day of care and monitoring that Petitioner needs, she is unwilling to do so, especially given that she has already agreed to provide unpaid care and monitoring to Petitioner for 2.75 hours per day.

LCMHA's authorization also fails to authorize any CLS to Petitioner for money management and medication administration, even though the parties agree that Petitioner cannot manage his own money nor administer his own medication. In addition, LCMHA's authorization fails to authorize any CLS for managing Petitioner's self-determination arrangement, repositioning Petitioner every two hours and toileting him as frequently as is needed each day. Finally, LCMHA's CLS authorization fails to authorize any hours for scheduling medical appointments, providing transportation, accompanying Petitioner to doctor's appointments, monitoring medications, coordinating care, maintaining medical equipment, and coordinating medical equipment replacement with the insurance company.

Furthermore, the fact that LCMHA did not increase Petitioner's respite when authorizing his CLS is also problematic. One would assume that if LCMHA is expecting Petitioner's mother to provide more unpaid care and monitoring for Petitioner than she was before, Petitioner's mother might require more respite, or rest, per week than what had been previously authorized at WCCMH. However, LCMHA not only did not increase Petitioner's respite, LCMHA failed to even conduct a respite assessment.

In addition, the authorization approved by LCMHA does not even match up with its own CLS assessment for Petitioner. As Petitioner points out, the CLS assessment indicates that Petitioner requires 17.83 hours of paid caregiving today. If one subtracts the 4.75 hours of AHH Petitioner receives per day, that leaves 13.08 hours of care, not the 11.5

CLS hours authorized per day by LCMHA. Also, as Petitioner points out, LCMHA seems to have relied almost exclusively on the CLS assessment in authorizing Petitioner's CLS hours, contrary to guidance from MDHHS. (See Exhibit 15)

Therefore, based on the evidence presented, LCMHA's decision was improper and should be reversed. LCMHA's decision was untimely and not supported by the evidence in the record. LCMHA offered no serious justification for a significant decrease in Petitioner's CLS when he simply moved between two counties within the same PIHP. Petitioner's condition is worsening, and he actually requires more care now than in the past. LCMHA failed to authorize CLS for numerous activities where CLS was provided before, such as medication management. LCMHA also failed to consider Petitioner's authorized respite when decreasing the amount of CLS he previously received. For all of these reasons, LCMHA's decision was improper and must be reversed.

At the conclusion of the hearing, Petitioner's Guardian, who is also a licensed attorney, made a motion for attorney fees under MCL 24.323, arguing that the agency's legal position was devoid of arguable legal merit.

> MCL 24.322 provides, in pertinent part:
>
> (1) The presiding officer that conducts a contested case shall award to a prevailing party, other than an agency, the costs and fees incurred by the party in connection with that contested case, if the presiding officer finds that the position of the agency to the proceeding was frivolous. To find that an agency's position was frivolous, the presiding officer shall determine that at least 1 of the following conditions has been met:
>
> (a) The agency's primary purpose in initiating the action was to harass, embarrass, or injure the prevailing party.
>
> (b) The agency had no reasonable basis to believe that the facts underlying its legal position were in fact true.
>
> (c) The agency's legal position was devoid of arguable legal merit.

Here, while Respondent's decision was untimely and ultimately incorrect, it cannot be said that LCMHA's position was "devoid of arguable legal merit". LCMHA did follow its normal intake procedures with Petitioner, including conducting a bio/psycho-social assessment, a CLS assessment, and an IPOS in coming to its conclusion, and relied on these documents when coming to its conclusion. While this conclusion was improper, it was not devoid of any arguable legal merit. As such, Petitioner's motion for attorney fees is denied.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly authorized Petitioner's CLS when he moved to Lenawee County in October 2020.

IT IS THEREFORE ORDERED that:

The CMH decision is REVERSED.

Within 10 days of receipt of this Order, CMH should take steps to begin another assessment of Petitioner's needs consistent with this decision.

RM/sb

Robert J. Meade
Administrative Law Judge

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

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

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

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

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

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