[redacted]
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Date Mailed: October 4, 2022
MOAHR Docket No.: 22-001912
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a hearing was held via video conferencing on September 21, 2022. Cassandra M. Sanders, an attorney with Disability Rights Michigan, appeared on behalf of Petitioner, Samuel Harman (Petitioner). Evan George, Fair Hearings Officer, appeared on behalf of Respondent, Washtenaw County Community Mental Health (Respondent or WCCMH).

During the hearing, the following witnesses testified:

Krista DeWeese, Program Administrator for I/DD Services, Respondent

Carmen Moore, Supports Coordinator, Respondent

Janice Lampman, Independent Facilitator

[redacted], Petitioner's Mother/Legal Guardian

The following exhibits were also entered into the record:

Petitioner's Exhibits:

Exhibit #1: Request for Hearing

Exhibit #2: Clinical Documentation in support of WCCMH's Notice of Resolution of Internal Review dated April 22, 2022

Exhibit #3: Amended Individual Plan of Service dated April 27, 2022

Exhibit #4: Self Determination Direct Employer Participant Agreement dated February 7, 2022

Exhibit #5: MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY22: Attachment C3.3.4, "Self-Determination Policy & Practice Guideline"

Exhibit #6: February 1, 2022 Emails from [redacted] to Carmen Moore and Holly Owen, Subject: S.H. – OHSS Request

Exhibit #7: January 14 – February 9, 2022 Emails between Kimberly Diebboll, Carmen Moore and other Washtenaw County CMH employees, Subject: RE: SH#20964 CLS Update

Exhibit #8: February 8 – February 10, 2022 Emails between Krista DeWeese, Carmen Moore and other Washtenaw County CMH employees, Subject: RE: SH 20964

Exhibit #9: March 1 – March 3, 2022 Emails between Kimberly Diebboll, Julie Lovelace and other Washtenaw County CMH employees, Subject: RE: SH#20964 CLS review – ABD Needed

Exhibit #10: March 3, 2022 Emails between Kimberly Diebboll, Shane Ray, Katie Snay, and other Washtenaw County CMH employees, Subject: FW: SH#20964 – Pay Rate Question

Exhibit #11: March 3, 2022 Emails between Kimberly Diebboll, Shane Ray, Katie Snay, and other Washtenaw County CMH employees, Subject: RE: SH#20964 – Pay Rate Question

Exhibit #12: March 3, 2022 Additional Emails between Kimberly Diebboll, Shane Ray, Katie Snay, and other Washtenaw County CMH employees, Subject: FW: SH#20964 – Pay Rate Question

Exhibit #13: Notice of Adverse Benefit Determination from Lenawee CMH Authority dated January 19, 2022

Respondent's Exhibits:

Exhibit A: Hearing Summary

Exhibit B: Notices of Adverse Benefit Determination

Exhibit C: Individual Plans of Service

Exhibit D: CLS Assessment Tool and CLS Request/Authorization Forms

Exhibit E: Progress Notes

Exhibit F: Self Determination Agreement

Exhibit G: CMHPSM Assessment and Authorization of CLS Services Policy

Exhibit H: CMHPSM Utilization and Management Review Policy

Exhibit I: MDHHS Medical Provider Manual Excerpt

Exhibit J: MDHHS PIHP Contract Attachment

ISSUES

Whether Respondent properly denied Petitioner's request for around-the-clock services?

Whether Respondent failed to timely provide approved 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] ([redacted]) year-old Medicaid beneficiary who has been diagnosed with spastic cerebral palsy and intellectual delays. (Exhibit C, pages 1-2; Exhibit E, page 1).

2. On November 24, 2021, Petitioner's mother/guardian contacted Respondent to request for services for Petitioner through it. (Exhibit E, page 1).

3. At that time, Petitioner was living in a specialized residential setting in Lenawee County and receiving services from the Lenawee County Community Mental Health Authority (LCCMHA), but he was also planning to move into the family home in Washtenaw County in January or February of 2022. (Exhibit E, page 1).

4. Petitioner's guardian, Respondent and the LCCMHA then began working on transitioning Petitioner's services over to Respondent. (Exhibit #1, pages 21, 28; Exhibit C, page 1; Testimony of Petitioner's guardian; Testimony of Supports Coordinator).

5. On December 21, 2021, an Individual Plan of Service (IPOS) meeting was held between Petitioner, Petitioner's mother/guardian, an Independent Facilitator identified by Petitioner, Petitioner's Supports Coordinator with Respondent, and a representative from LCCMHA. (Exhibit #1, pages 21, 28; Exhibit C, page 1).

6. During that meeting and other, subsequent conversations, Petitioner's guardian indicated that she was requesting around-the-clock services for Petitioner, *i.e.,* 168 hours per week, and that she wanted to utilize self-determination. (Exhibit #1, page 22; Exhibit #8, pages 104-105; Exhibit E, page 4; Testimony of Petitioner's guardian; Testimony of Supports Coordinator).

7. On January 5, 2021, LCCMHA completed an assessment of Petitioner for Community Living Supports (CLS). (Exhibit #2, page 61; Exhibit E, page 4).

8. During that assessment, Petitioner's guardian requested staffing 24 hours a day, 7 days a week; requested to use self-determination; identified one staff worker for Petitioner, *i.e.,* Petitioner's brother; and reported that she is not able to provide care. (Exhibit E, pages 4-5).

9. However, on January 13, 2022, after it was reported that Petitioner's brother could only work 24 hours per week and a case manager at LCCMHA expressed concerns that Petitioner may not have enough staff, particularly given staffing shortages in the area, Petitioner's guardian reported that she will provide care if she needs to. (Exhibit E, page 5).

10. LCCMHA subsequently determined that Petitioner should only be approved for 77 hours per week of CLS and, on January 19, 2022, sent Petitioner's guardian a Notice of Adverse Benefit Determination stating that her request for 24 hours of CLS services had been partially denied and that only 77 hours per week of such services would be approved. (Exhibit #2, page 63; Exhibit #13, page 123; Exhibit B, page 7).

11. Petitioner's guardian did not appeal that determination made by LCCMHA. (Testimony of Petitioner's guardian).

12. Both Respondent and LCCMHA also informed Petitioner that Respondent would honor the CLS authorization completed by LCCMHA and temporarily approve Petitioner for 77 hours per week of CLS until an updated CLS assessment could be completed. (Exhibit D, page 5; Exhibit E, page 6; Testimony of Petitioner's guardian).

13. Respondent also completed its own CLS assessment in January of 2022 in which it determined that 112 hours per week of CLS should be approved for three months while waiting for an approval of Home Help Services (HHS) and a day program for Petitioner. (Exhibit D, pages 1- 5).

14. However, while a note from Respondent's Utilization Management provided that a Notice of Adverse Benefit Determination needed to go out, as Respondent was denying Petitioner's request for 168 hours per week of CLS, no such notice was sent. (Exhibit D, page 2; Testimony of Petitioner's guardian; Testimony of Program Administrator).

15. Moreover, the partial approval of 112 hours per week was not implemented and Petitioner's IPOS with Respondent at the time only stated that Petitioner was approved for 77 hours per week of CLS. (Exhibit #1, page 21; Exhibit #8, pages 104-105; Exhibit C, page 1).

16. The IPOS did provide that Petitioner's CLS was through self-determination, and it identified Petitioner's mother/guardian as his natural support. (Exhibit #1, page 22; Exhibit C, page 2).

17. On January 29, 2022, Petitioner moved in with his mother/guardian. (Exhibit D, page 6; Testimony of Petitioner's guardian).

18. On February 7, 2022, Petitioner's guardian signed a Self-Determination/Choice Voucher Direct Employer Participant in which Petitioner agreed in part that: "The participant will make arrangements, as necessary, for obtaining paid staff and unpaid/natural supports to accomplish the goals and outcomes of his or her IPOS." (Exhibit #4, page 76; Exhibit F, page 4).

19. Petitioner then began utilizing some of his approved CLS hours through one part-time staff worker, his brother. (Exhibit #6, page 101; Testimony of Petitioner's guardian).

20. However, most of Petitioner's authorized hours went unutilized due to a lack of staff. (Exhibit #6, page 98; Testimony of Petitioner's guardian; Testimony of Supports Coordinator).

21. To alleviate the lack of staff, Petitioner's guardian requested assistance from Respondent in locating workers, but, while some referrals were provided, Petitioner's guardian was still unable to locate workers. (Exhibit #6, page 96; Exhibit #10, pages 110-111; Testimony of Petitioner's guardian; Testimony of Supports Coordinator).

22. Petitioner's guardian also continued to request around-the-clock services for Petitioner, whether in the form of CLS or a combination of services, including Overnight Health and Safety Support (OHSS) services. (Exhibit #6, pages 98-99; Testimony of Petitioner's guardian).

23. On March 1, 2022, Respondent completed a reassessment of Petitioner's CLS and his request for 168 hours of services per week. (Exhibit #1, page 55; Exhibit #9, pages 107-108).

24. As part of that review, Respondent noted that Petitioner's mother/guardian did not want to provide natural support. (Exhibit #11, page 114).

25. However, Respondent also subsequently determined that Petitioner's mother/guardian could provide 56 hours per week of natural supports and that Petitioner should therefore only be approved for 112 hours per week

of CLS, with Petitioner's IPOS finally amended to change his CLS hours from 77 hours per week to 112 hours per week. (Exhibit C, page 7; Exhibit #9, pages 107-108; Testimony of Program Administrator).

26. On March 2, 2022, Respondent sent Petitioner's guardian a Notice of Adverse Benefit Determination stating that Petitioner's request for 168 hours per week of services was denied on the basis that the services were not "medically necessary as natural supports should be utilized." (Exhibit B, page 1).

27. On March 31, 2022, Petitioner, through his attorney, filed an Internal Appeal regarding that decision. (Exhibit #1, pages 35-40, 42).

28. In addition to appealing the denial of around-the-clock services, Petitioner also argued in the appeal that Petitioner had failed to timely provide the currently authorized services in the IPOS. (Exhibit #1, pages 39-40).

29. On April 22, 2022, Respondent sent Petitioner's representative a Notice of Resolution of Internal Review, stating in part that:

> The WCCMH Local Review Committee determined that the denial of CLS & Overnight Support Services is upheld.
>
> Prior to moving [Petitioner] from his residential facility to the family home, clinical documentation indicated the guardian, [Petitioner's mother], was agreeable to fewer CLS hours than the current request. The guardian later indicated that she was refusing to provide any natural support hours. No information was provided as to whether she was able to do so. This prevented CMH from evaluating or utilizing natural supports per the Community Mental Health Partnership of Southeast Michigan (CMHPSM) Community Living Supports (CLS) policy. Consequently, the requested authorization was reduced by 8 hours a day, the amount that parents of recipients residing in the same home typically provide when they can do so.

Exhibit #1, page 42

30. On April 29, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed on Petitioner's behalf in this matter alleging an (1) improper denial of Petitioner's request for around-the-clock services and (2) a failure by Respondent to timely provide services that were approved. (Exhibit #1, pages 1-59).

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)) (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 (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 has been receiving Community Living Supports (CLS) services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **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 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 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 MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS 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 MDHHS 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 MDHHS 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 children and youth 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.
>
> *MPM, January 1, 2022 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 136-137*

Moreover, Petitioner's guardian also requested Overnight Health and Safety Support (OHSS) services through Respondent. With respect to those services, the MPM states in part:

> **2.11 OVERNIGHT HEALTH AND SAFETY SUPPORT (OHSS) SERVICES**
>
> NOTE: OHSS is not available for individuals residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian.
>
> **2.11.A. ELIGIBILITY**
>
> To be eligible for OHSS, an individual must:
>
> - Be Medicaid eligible;
> - Be enrolled in one of the following waiver programs: CWP, HSW, or SEDW;
> - Be living in a community-based setting (not in a hospital, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID], nursing facility, licensed Adult Foster Care home, correctional facility, or child caring institution); and
> - Require supervision overnight to ensure and maintain the health and safety of an individual living independently.
>
> The need for OHSS must be reviewed and established through the person-centered planning process with the beneficiary's specific needs identified that outline health

and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety.

2.11.B. COVERAGE

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the Individual Plan of Service (IPOS), encompassing both health and safety support services needed for the individual to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.

- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow an individual to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is

implemented.

- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night.

- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).

- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.

- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.

- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.

- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury

> or illness that poses an immediate risk to a person's life.
>
> - OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
>
> - OHSS is not available for an individual who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.
>
> - OHSS is not intended to compensate or supplant services for the relief of the primary caregiver or legal guardian living in the same home or to replace a parent's obligations and parental rights of minor children living in a family home
>
> - OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.
>
> *MPM, January 1, 2022 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages B10-B-12*

At the request of Petitioner's guardian, both CLS and any OHSS services were to be provided through self-determination. With respect to self-determination, the MDHHS Behavioral Health and Developmental Disabilities Self-Determination Policy & Practice Guidelines state in part:

> Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include: work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they

want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

* * *

CORE ELEMENTS

I. People are provided with information about the principles of self-determination and the possibilities, models and arrangements involved. People have access to the tools and mechanisms supportive of self-determination, upon request. Self-determination arrangements commence when the PIHP/CMHSP and the individual reach an agreement on an individual plan of services (IPOS), the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.

* * *

III. People receiving services and supports through the public mental health system shall direct the use of resources in order to choose meaningful specialty mental

health services and supports in accordance with their IPOS as developed through the person-centered planning process.

* * *

V. Realization of the principles of self-determination requires arrangements that are partnerships between the PIHP/CMHSP and the individual. They require the active commitment of the PIHP/CMHSP to provide a range of options for CORE ELEMENTS, continued individual choice and control of personalized provider relationships within an overall environment of person-centered supports.

VI. In the context of this partnership, PIHP/CMHSPs must actively assist people with prudently selecting qualified providers and otherwise support them with successfully using resources allocated in an individual budget.

* * *

IX. Arrangements that support self-determination are administrative mechanisms, allowing a person to choose, control and direct providers of specialty mental health services and supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and mental health specialty services and supports. Self-determination arrangements must be developed and operated within the requirements of the respective contracts between the PIHPs and CMHSPs and the Michigan Department of Health and Human Services and in accordance with federal and state law. Using arrangements that support self-determination does not change an individual's eligibility for particular specialty mental health services and supports.

* * *

POLICY

I. Opportunity to pursue and obtain an IPOS incorporating arrangements that support self-determination shall be established in each PIHP/CMHSP, for adults with developmental disabilities and adults with mental illness. Each PIHP/CMHSP shall develop and make available a set of methods that provide opportunities for the person to control and direct their specialty mental health services and supports arrangements.

   A. Participation in self-determination shall be a voluntary option on the part of each person.

   B. People involved in self-determination shall have the authority to select, control and direct their own specialty mental health services and supports arrangements by responsibly controlling the resources allotted in an individual budget, towards accomplishing the goals and objectives in their IPOS.

   C. A PIHP/CMHSP shall assure that full and complete information about self-determination and the manner in which it may be accessed and applied is provided to everyone receiving mental health services from its agency. This shall include specific examples of alternative ways that a person may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully.

   D. Self-determination shall not serve as a method for a PIHP/CMHSP to reduce its obligations to a person or avoid the provision of needed specialty mental health services and supports.

   E. Each PIHP/CMHSP shall actively support and facilitate a person's application of the principles of self-determination in the accomplishment of his/her IPOS.

Exhibit #5, pages 80-84

Additionally, whether through self-determination or traditional arrangements, any service authorized through Respondent must be medically necessary. Regarding the required medical necessity, the MPM also provides:

> **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.

Here, as discussed above, Petitioner's guardian requested around-the-clock services for Petitioner; Respondent denied the request and only approved 112 hours per week of CLS; and Petitioner has requested a hearing with respect to that decision. Moreover, Petitioner has also requested a hearing on the basis that Respondent has failed to timely provide the CLS services that were authorized.

In requesting a hearing, 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 Respondent's decisions in light of the information it had at the time it made any decision.

Each of Petitioner's claims with be addressed in turn and, for the reasons discussed below, the undersigned Administrative Law Judge finds that, while Petitioner's claim that Respondent failed to timely provide services should be dismissed, Petitioner has met his burden of proving by a preponderance of the evidence that Respondent erred in denying the request for around-the-clock services; Respondent's decision must be reversed; and Respondent should initiate a reassessment of Petitioner's request.

Denial of Around-the-Clock Services

In denying Petitioner's request for around-the-clock services, Respondent's initial notice stated that the request was denied on the basis that the services were not "medically necessary as natural supports should be utilized."[1] Other evidence demonstrated that Respondent specifically found that Petitioner's mother could provide 56 hours per week of natural supports, and that only 112 hours per week of CLS should be approved, with Petitioner's mother providing the remaining 56 hours in a week.[2]

In responding to Petitioner's Internal Appeal, Respondent identified the same reason for denying the request, while also addressing the availability of natural supports in more detail:

> Prior to moving [Petitioner] from his residential facility to the family home, clinical documentation indicated that the guardian, [Petitioner's mother], was agreeable to fewer CLS hours than the current request. The guardian later indicated she was refusing to provide any natural support hours. No information was provided as to whether she was able to do so. This prevented CMH from evaluating or utilizing natural supports per the Community Mental Health Partnership of Southeast Michigan (CMHPSM) Community Living Supports (CLS) policy.

[1] *See* Exhibit B, page 1.
[2] *See* Exhibit C, page 7; Exhibit #9, pages 107-108; Testimony of Program Administrator.

> Consequently, the requested authorization was reduced by 8 hours a day, the amount that parents of recipients residing in the same home typically provide when they can do so.
>
> *Exhibit #1, page 42*

Given that record alone, Petitioner has met his burden of demonstrating by a preponderance of the evidence that Respondent erred in denying his request for around-the-clock services.

Respondent undisputedly must take Petitioner's natural supports into account when determining medical necessity. However, it is also undisputed that those natural supports must also be willing and able to provide care. Here, as acknowledged in the denial of the Internal Appeal, Petitioner's mother had expressly stated that she was refusing to provide any natural support hours and, consequently, Respondent erred in allocating 56 hours per week of care to her on the basis that she was willing and able to do so.

Moreover, the language used in the denial to justify the findings of 56 hours of natural supports is likewise clearly defective. Respondent stated that it reduced the requested authorization by 8 hours a day because Petitioner's mother's statement that she was refusing to provide natural supports prevented Respondent from determining if she was able to do so and 8 hours a day was the amount that parents of recipients residing in the same home typically provide when they can do so. However, if Petitioner's mother is refusing to provide natural supports, it does not matter if she is able to do so and assigning any hours is inappropriate.

Similarly, Respondent's argument and evidence during the hearing is likewise flawed. Respondent's Program Administrator testified, and Respondent argued that, as Petitioner's guardian moved Petitioner into the family home knowing that he was not approved for around-the-clock services and that she would have to provide natural supports, she implicitly agreed to be a natural support for Petitioner. However, even if Petitioner's mother implicitly agreed to be a natural support temporarily and until Respondent conducted an assessment, that does not mean she agreed to be a natural support forever; she has the right to change her mind regardless; and, by the time of the decision in this case, Respondent definitively knew that she did not want to be a natural support.

Petitioner's mother credibly testified that, while she currently provides care to keep Petitioner safe and healthy, she does not want to provide natural supports. That unwillingness is undisputed and, consequently, Respondent erred by taking natural support from Petitioner's mother into account when authorizing hours. Accordingly, Respondent's decision must be reversed.

Failure to Timely Provide Services

As discussed above, Petitioner also argues that Respondent failed to provide services in a timely manner.

Specifically, Petitioner argued in his request for hearing/brief that Petitioner has not yet received the majority of services he was authorized for months ago as Respondent, who has an inadequate network of providers, has been unable to find an agency or staff to provide Petitioner's services. Petitioner also argued that Petitioner's guardian has been forced into using self-determination so that she could hire part-time staff to at least cover some of Petitioner's hours.

During the hearing, Petitioner's guardian similarly testified that she did not think she had a choice about utilizing self-determination given that the alternatives were putting Petitioner into an institution or relying on Respondent to find an agency, which was not guaranteed. She also testified that she has repeatedly reached out to Respondent asking for assistance in hiring staff, but that Respondent has not been able to find any for her.

In response, Respondent argued in its brief that there has not been a failure to timely provide services, or any other negative action taken with respect to Petitioner's authorized services, and that the undersigned Administrative Law Judge therefore lacks jurisdiction in this matter. Respondent also argued that Respondent has continually been willing to pay for the services, but that Petitioner's guardian voluntarily chose self-determination and that, consequently, she took on the responsibility of finding and hiring staff. Respondent further argued that it has provided some assistance and looked into providers at Petitioner's guardian's request, but that Petitioner always wanted self-determination.

The failure to provide Medicaid services in a timely manner is an adverse benefit determination that can lead to a State fair hearing like the one held in this case. *See* 42 CFR 438.400(b)(4).

However, there was no such failure in this case and Petitioner's claim regarding such a failure should be dismissed for lack of jurisdiction.

The services Petitioner alleges that Respondent failed to timely provide are his CLS services, but it is undisputed that Petitioner's guardian elected to utilize those services through self-determination and that Respondent authorized payment for them as required. Moreover, by the express terms of the self-determination agreement, Petitioner's guardian was the one responsible for making the necessary arrangements for obtaining paid staff[3] and, as such, Respondent did not fail to provide services by failing to find staff.

[3] *See* Exhibit #4, page 76; Exhibit F, page 4.

Additionally, to the extent Petitioner argued or his guardian testified that Petitioner was forced into a self-determination agreement, the undersigned Administrative Law Judge does not find that to be persuasive as the record established that, from the very beginning, Petitioner wanted self-determination[4] and any speculative concerns underlying that decision, while perhaps justified, does not shift the burden to Respondent to provide staff once Petitioner's decision to utilize self-determination is made.

Similarly, to the extent that Petitioner argues that Respondent's failure to support Petitioner's utilization of self-determination and assist Petitioner's guardian in finding providers constitutes a failure to timely provide services, that argument is likewise unpersuasive. Respondent does have obligations under the self-determination agreement, including generally assisting Petitioner and specifically assisting Petitioner in creating a back-up plan[5], but an alleged failure to meet those obligations does not constitute a denial of service, with the MDHHS' own Policy & Practice Guidelines expressly stating that:

> Arrangements that support self-determination are administrative mechanisms, allowing a person to choose, control and direct providers of specialty mental health services and supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and mental health specialty services and supports.

Exhibit #5, page 83

The same Policy & Practice Guidelines also provide that, as the arrangements that support self-determination involve mental health specialty services and supports, the investigative authority of the Recipient Rights office applies[6] and Petitioner's guardian is free to file a Recipients Rights complaint if she wishes.

Petitioner likewise remains free to file a grievance with Respondent regarding any alleged failures on Respondent's part to support self-determination, with the definition of grievance including an expression of dissatisfaction about quality of care or any other matter other than an adverse benefit determination.[7]

Whatever other avenues of relief Petitioner may choose to pursue, if any, he has failed to meet his burden of showing that there has been any failure to provide services in a timely manner in this case and his claim on that basis must therefore be dismissed for a lack of jurisdiction.

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[4] *See* Exhibit #1, page 22; Exhibit #8, pages 104-105; Exhibit E, page 4; Testimony of Petitioner's guardian; Testimony of Supports Coordinator.
[5] *See* Exhibit #4, pages 74-75.
[6] *See* Exhibit #5, page 83.
[7] *See* MCL 42 CFR 438.400(b).

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that, while Petitioner's claim that Respondent failed to provide services in a timely manner must be dismissed, Respondent erred when denying Petitioner's request for around-the-clock services.

IT IS THEREFORE ORDERED that:

- Petitioner's claim that Respondent failed to provide services in a timely manner is **DISMISSED.**

- Respondent's denial of Petitioner's request for around-the-clock services is **REVERSED** and it must initiate a reassessment of Petitioner's request.

Steven Kibit

SK/dh

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

Via Electronic Mail:

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