GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
DIRECTOR

[redacted]

Date Mailed: May 14, 2024
MOAHR Docket No.: 24-003482
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is 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 request for a hearing.

After due notice, a hearing was held on May 2, 2024. [redacted] Petitioner's Adoptive Mother, appeared and testified on Petitioner's behalf.

April Higgins appeared and testified on behalf of Respondent, Community Mental Health for Central Michigan. (Department) Angela Zywicki, Utilization Management appeared as a witness for Respondent.

ISSUE

Did the Department properly deny Petitioner's request for Overnight Health & Safety (ONHS) services, and Community Living Supports (CLS) 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 Medicaid beneficiary under the 1915(**I**)SPA waiver, who has been diagnosed with major depressive disorder, unspecified anxiety disorder, parental-child relationship problem, attention-deficit/hyperactivity disorder, oppositional defiant disorder, personal history of psychological trauma, constipation, and educational problems. (Exhibit A; Testimony.)

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

3. Petitioner's legal residence is with her adoptive family in Big Rapids but spends the majority of her time at her Respite providers home in Midland due to a need to provide space between her adoptive family and Petitioner and to continue attending school at a familiar place rather than moving into a new environment. (Exhibit A; Request for Hearing; Testimony.)

4. On February 2, 2024, Petitioner underwent a psychosocial assessment. (Exhibit A.)

5. On or around February 26, 2024, Petitioner requested ONHS services and additional CLS services through a self-determination arrangement to provide services while Petitioner was outside of Petitioner's home with Petitioner's provider in Midland. (Exhibit A; Testimony.)

6. On February 26, 2024, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice stated the following:

> … Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence, or productivity. The supports may be provided in the beneficiary's residence or in community settings. Due to a change of living arrangements, a request for CLS while consumer is living at a provider staff's home would not meet the eligibility per the Medicaid manual.[1]

7. On March 17, 2024, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's request for ONHS was denied as the service may not be provided outside of consumer's community. (Exhibit A.)

8. On March 19, 2024, the Petitioner filed an internal appeal regarding the ONHS services denial. (Exhibit A.)

9. On March 21, 2024, the Department sent Petitioner a Notice of Appeal Denial. The notice indicated the following:

> Review took place of the Medicaid Manual for how and where H2015 Community Living Supports (CLS)

[1] Exhibit A.

> services can be provided, expectations for natural support (parent and others) before using CLS.
>
> Section 17.3 "Criteria for Authorizing BH 1915(I)SPA Supports and Services
>
> Section 17.4.A. Community Living Supports (CLS)
>
> Review also took place of the Michigan Department of Health and Human Services (MDHHS) Behavioral Health Code Sets, Charts, and Provider Qualifications which also indicates that the place of service for H2015 CLS is in the consumers home or the community. Farrah's (Provider-Midland) home is neither.
>
> Both H2015 CLS and T2027 Overnight Health and Safety were reviewed for the request of night care. T2027 is not available unless the consumer is on the Severely Emotionally Disturbed Waiver, Habilitative Support Waiver, or Children's Waiver. This is not a service allowed under the 1915(I) SPA Waiver.
>
> H2015 CLS can only be provided in the consumers home or the community Farrah's home is neither [redacted] home or considered "community" as it is a home setting. There is no billable CLS service code that can be provided in a staff person or another person's home.
>
> It is expected that parents provide the same care to a child with disabilities that they would to a child without. There is still an expectation that parents are providing daily support in ways that would be typically expected of a parent. In living outside of the home for days at a time, parents are not given the ability to provide this parental support daily.[2]

10. On March 21, 2024, the Department issued a second Notice of Appeal Denial. The second notice stated the following:

> Review took place of the Medicaid Manual for how and where H2015 Community Living Supports (CLS) services can be provided, expectations for natural support (parent and others) before using CLS.

[2] Exhibit A.

> Section 17.3 "Criteria for Authorizing BH 1915(I)SPA Supports and Services
>
> Section 17.4.A. Community Living Supports (CLS)
>
> Review also took place of the Michigan Department of Health and Human Services (MDHHS) Behavioral Health Code Sets, Charts, and Provider Qualifications which also indicates that the place of service for H2015 CLS is in the consumers home or the community. Farrah's (Provider-Midland) home is neither.
>
> Both H2015 CLS and T2027 Overnight Health and Safety were reviewed for the request of night care. T2027 is not available unless the consumer is on the Severely Emotionally Disturbed Waiver, Habilitative Support Waiver, or Children's Waiver. This is not a service allowed under the 1915(I) SPA Waiver.
>
> H2015 CLS can only be provided in the consumers home or the community Farrah's home is neither [redacted] home or considered "community" as it is a home setting. There is no billable CLS service code that can be provided in a staff person or another person's home.
>
> It is expected that parents provide the same care to a child with disabilities that they would to a child without. There is still an expectation that parents are providing daily support in ways that would be typically expected of a parent. In living outside of the home for days at a time, parents are not given the ability to provide this parental support daily.
>
> At this time, the services being requested are not able to be provided in the current environment requested. If [redacted] were to return to their home, CLS and respite could be appropriate based on the needs indicated by the family, and because [redacted] would be back in her home.[3]

11. On April 3, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Hearing File.)

[3] Exhibit A.

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.[4]
>
> 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.[5]

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…[6]

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

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[4] 42 CFR 430.0.
[5] 42 CFR 430.10.
[6] 42 USC 1396n.

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.[7]

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.

[7] *See 42 CFR 440.230.*

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.[8]

17 BEHAVIORAL HEALTH §1915(I) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN AMENDMENT

HCBS provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.

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[8] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2024, pp 13-15.

17.3 CRITERIA FOR AUTHORIZING BH 1915(I) SPA SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the BH 1915(i) SPA 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;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's individual plan of service; and
- Additional criteria indicated in certain BH 1915(i) SPA service definitions, as applicable.

Decisions regarding the authorization of a BH 1915(i) SPA 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 BH 1915(i) SPA 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 their 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.

Refer to the Behavioral Health Code Charts and Provider Qualifications document for supports and services provider qualifications. The Behavioral Health Code Charts and Provider Qualifications document is

posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

17.4 BH 1915(I) SPA SUPPORTS AND SERVICES

The BH 1915(i) SPA supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.4.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary'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 activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary'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 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. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them 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.

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CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary'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 beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.

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17.4.G. RESPITE CARE SERVICES

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

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

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

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

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

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

If an adult beneficiary living at home is receiving home help services and has hired their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)

- Home of a friend or relative chosen by the beneficiary and members of the planning team

- Licensed camp

- In community (social/recreational) settings with a respite worker trained, if needed, by the family

- Licensed family child care home

Respite care may not be provided in:

- day program settings
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- nursing homes
- hospitals

Respite care may not be provided by:

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

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.[9]

The Department argued ONHS services were not available to Petitioner due to the Petitioner not being on a waiver the provides for those services. The Department further indicated that CLS services were not appropriate as CLS services are to be provided in the consumers residence or community and this case, they were being requested to be provided in the residence of Petitioner's respite provider.

The Petitioner did not dispute the policy or identify any policy that would cover ONHS services. Consequently, the Department's determination to deny Petitioner's request for ONHS should be affirmed.[10]

Regarding the CLS services, Petitioner offered the current living arrangement was only temporary and until school let out, at which point, Petitioner would return to her legal residence with her adoptive family. The Petitioner focused on the temporary nature of the situation and did not present much of an argument as to how the policy identified above permitted Petitioner to receive CLS services at both locations. Nor did the

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[9] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2024, pp 149-150, 157-159.

[10] "An appellant may not merely announce a position then leave it to this Court to discover and rationalize the basis for the appellant's claims; nor may an appellant give an issue only cursory treatment with little or no citation of authority." *Chessman v Williams*, 311 Mich App 147, 161; 874 NW2d 385 (2015).

Petitioner identify specific needs that would necessitate CLS services at both residences outside the typical care parents of minor children with disabilities would provide to children without disabilities.

Petitioner bears the burden of proving by a preponderance of the evidence that they are entitled to the benefits being requested. Based on the evidence presented, Petitioner has failed to meet their burden.

Based on the evidence presented, the Department's decision was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly denied Petitioner's request for services.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

CA/pe

Corey Arendt
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

Via Electronic Mail:

DHHS Department Contacts

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Via First Class Mail:

Petitioner

[redacted]