[redacted]

Date Mailed: June 28, 2024
MOAHR Docket No.: 24-005256
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on June 12, 2024. [redacted] Petitioner's legal guardian, appeared and testified on Petitioner's behalf. Stacy Coleman, Contractor, appeared and testified on behalf of Respondent Macomb County Community Mental Health (Respondent). Misty Lawrence, the Chief Executive Officer (CEO) of My Independent Living, Petitioner's paid care provider, and Bridget Zabawa, Petitioner's Case Manager at Respondent, also testified as witnesses.

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

Exhibit #1:	Request for Hearing
Exhibit A:	Notice of Adverse Benefit Determination
Exhibit B:	Notice of Appeal Denial
Exhibit C:	Person Centered Plan Addendum

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS) for the period of March 1, 2024, to March 21, 2024?

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 an [redacted] year-old Medicaid beneficiary who has a legal guardian and who has been diagnosed with a mild intellectual disability; unspecified bipolar and anxiety disorder; hypothyroidism; gastroesophageal reflux disease; an overactive bladder; hypertension;

anemia; and hyperlipidemia. (Exhibit C, page 1; Testimony of Petitioner's representative).

2. Due to her diagnoses and need for assistance, Petitioner has been approved for services through Respondent. (Exhibit C, pages 1-14).

3. As part of Petitioner's approved services for the period of September 1, 2023, to August 31, 2024, Respondent authorized Petitioner for 56 hours per week of CLS. (Exhibit C, page 6).

4. On February 4, 2024, Petitioner was hospitalized after falling in her home. (Exhibit C, page 1).

5. She was also diagnosed with vasovagal syncope and presyncope. (Testimony of Respondent's representative).

6. On February 6, 2024, Petitioner was discharged from the hospital. (Exhibit C, page 1).

7. Following her discharge, Petitioner's guardian requested an additional 98.5 hours per week of CLS for Petitioner for 3 months. (Exhibit C, page 1; Testimony of Petitioner's representative; Testimony of Respondent's representative; Testimony of Case Manager).

8. Along with the request, Petitioner's guardian provided a prescription from Petitioner's doctor identifying a need for additional services for 3 months. (Testimony of Petitioner's representative; Testimony of Case Manager).

9. Petitioner's guardian and her care provider were then verbally advised by the Supervisor for Petitioner's Case Manager that Petitioner's request was approved based on the doctor's prescription. (Testimony of Petitioner's representative; Testimony of CEO of My Independent Living).

10. However, while additional services for 3 months were requested and approved, the Addendum to Petitioner's Person-Centered Plan (PCP) indicated that the additional services were only approved for the period of February 6, 2024, to February 29, 2024. (Exhibit C, page 10).

11. Respondent did not send any written notice of a denial or limited authorization with respect to Petitioner's request for additional services for 3 months. (Testimony of Respondent's representative).

12. If Respondent had only authorized the additional services for 1 month, instead of the requested 3, it was required to send an Adverse Benefit Determination. (Testimony of Respondent's representative).

13. Pursuant to Respondent's approval, Petitioner's care provider agency provided the additional services in February and March of 2024. (Testimony of Petitioner's representative; Testimony of CEO of My Independent Living).

14. When the care provider agency attempted to bill for additional services provided in March of 2024, its claims were denied. (Testimony of CEO of My Independent Living).

15. The care provider agency stopped providing additional services on March 22, 2024. (Testimony of CEO of My Independent Living).

16. Petitioner's guardian also re-requested additional CLS services through May 24, 2024. (Testimony of Petitioner's representative; Testimony of Respondent's representative; Testimony of Case Manager).

17. On March 26, 2024, Respondent sent Petitioner a written Adverse Benefit Determination stating that the request for additional CLS had been denied. (Exhibit A, pages 1-7).

18. Specifically, the Adverse Benefit Determination stated in part:

> Based on review of clinical documentation, there does not appear to be a significant clinical change to your behavioral health needs to support this request. You are currently authorized for 8 hours/day of this service. This volume of service is sufficient in amount, scope and duration to reasonably achieve its purpose as documented in the individual plan of service.
>
> *Exhibit A, page 1*

19. Petitioner then filed an Internal Appeal with Respondent with respect to that Notice of Adverse Benefit Determination. (Exhibit B, page 1).

20. On April 26, 2024, Respondent sent Petitioner written notice that the Internal Appeal had been denied. (Exhibit B, pages 1-6).

21. Specifically, the Notice of Appeal Denial stated in part:

> [Y]ou asked for 98.5 hours of Community Living Supports (CLS) from 3/1/24 to 5/25/24. There has not been a big change in your behavioral health needs that show you need the 98.5 hours of increased Community Living Supports that you asked for this time. You

> have had 8 hours/day of Community Living Support since 2022. You also have 72.10 hours/month of Adult Home Health. After reading your plan of service, annual assessment and other supporting reports, there is no support for the increase in Community Living Supports and the request is denied for not meeting medical necessity.

Exhibit B, page 1

22. On May 9, 2024, MOAHR received the request for hearing filed in this matter. (Exhibit #1, pages 1-5).

23. During the hearing, Petitioner's representative expressly testified that Petitioner is only seeking additional CLS for the period of March 1, 2024, to March 21, 2024, during which CLS was provided, but no reimbursement was made. (Testimony of Petitioner's representative).

CONCLUSIONS OF LAW

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

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

42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other

> applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

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

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

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

Here, as discussed above, has been receiving Community Living Supports (CLS) through Respondent, and, with respect to such services, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **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.

- CLS staff providing 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 beneficiary in order that they 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 Medicaid FFS 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 CLS.

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 services when the beneficiary's need for this assistance has been officially determined to exceed the 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.

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.

MPM, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 150-152

While CLS are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding 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.

MPM, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15

Here, as discussed above, on March 26, 2024, Respondent denied Petitioner's request for additional Community Living Supports (CLS) for the period of March 1, 2024, to May 25, 2024.

Petitioner then requested a hearing with respect to additional CLS already provided between March 1, 2024, and March 21, 2024.

In appealing the denial, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law

Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

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

It is undisputed that, on February 6, 2024, Petitioner's guardian requested an additional 98.5 hours per week of CLS for Petitioner for 3 months. Moreover, the request included a prescription from Petitioner's doctor for such services for 3 months and was conveyed to Respondent by Petitioner's Case Manager before the Case Manager went on vacation.

The record also demonstrates that the request for additional services for 3 months, including the period at issue in this case, was then approved. Specifically, both Petitioner's guardian and the CEO of her care provider agency credibly testified that they were verbally advised by the Supervisor for Petitioner's Case Manager that Petitioner's request was approved based on the doctor's prescription, with both that prescription and the request itself identifying a need for additional services for 3 months. Similarly, the Case Manager testified that she believed the request had been fully approved for 3 months.

Respondent asserts in response that, as reflected in PCP Addendum, the additional services were only approved through February 29, 2024, but there is no evidence that any such limited approval was ever conveyed to Petitioner's guardian, her care provider, or her Case Manager.

Moreover, as conceded by Respondent's representative, written notice should have been sent. if there had been such a limited approval, and no such notice was sent in this case. The Code of Federal Regulations expressly requires that Respondent issue an Adverse Benefit Determination for limited authorizations of requested services, *see* 42 CFR 438.00, 42 CFR 438.404, and Respondent never issued any such Adverse Benefit Determination with respect to Petitioner's request on February 6, 2024 for additional CLS for 3 months.

Accordingly, given the lack of any notice regarding a limited authorization and the credible testimony providing that Petitioner's request for additional CLS was approved for 3 months, the services provided between March 1, 2024 to March 21, 2024, were authorized prior to being provided and Respondent erred by both initially failing to pay for them and retroactively denying them.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for additional CLS during the period of March 1, 2024, to March 21, 2024.

IT IS THEREFORE ORDERED that:

> Respondent's decision is **REVERSED,** and it must initiate a reassessment of and reimbursement for the additional CLS provided during the period of March 1, 2024, to March 21, 2024.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

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

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

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

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

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 28th day of June 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic & First Class Mail:

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