[redacted]
[redacted] MI [redacted]

Date Mailed: March 21, 2025
MOAHR Docket No.: 24-013946
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 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on March 18, 2025. [redacted] Petitioner's Guardian, appeared on behalf of Petitioner. Jennifer Fitch, Fair Hearing Officer, appeared on behalf of Respondent, Lifeways (Department). Mikal Chall and Amy Williams observed the proceeding on behalf of Department.

Exhibits:

| | |
|---|---|
| Petitioner | None |
| Department | A – Hearing Summary |

## ISSUE

Did Department properly reduce Petitioner's Community Living Supports (CLS)?

## 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 residing at [redacted] and who receives services from the Department. (Exhibit A; Testimony.)

2. Petitioner has a diagnosis of other specified schizophrenia spectrum/other psychotic disorder and a secondary diagnosis of epilepsy. (Exhibit A; Testimony.)

3. Petitioner receives Direct Court Ordered services through Segue and her treatment plan is reviewed/updated yearly to ensure she is receiving the appropriate level of care. (Exhibit A.)

4. On November 12, 2024, Petitioner requested additional CLS services. (Exhibit A; Testimony.)

5. At the time of the request, there was insufficient documentation accompanying the request to render a decision; so a delay notice was sent to Petitioner. (Exhibit A; Testimony.)

6. On November 27, 2024, the Department sent Petitioner a negative action notice. The notice indicated Petitioner did not have a medical necessity for such a high level of services and Petitioner's CLS services would be reduced to 53 units. The notice stated specifically:

> This is to notify you that the [redacted] in-home and community CLS authorization for [redacted] is approved at a reduced amount because there is not medical necessity in the chart to show need for overnight CLS other than occasional reminders to wash hands after using the restroom so sleep hours must be reduced out. She reportedly sleeps 10 hours per night x4 units = 40 units per day. 96 units per day total need – 3 units per day LifeSpan CLS – 40 units per day sleep = 53 units (13.25 hours) per day of CLS approved. This reduction to 53 units per day will start on 12/8/2024.[1]

7. On December 9, 2024, the Department received from Petitioner, an appeal of the November 27, 2024, negative action notice. (Exhibit A; Testimony.)

8. On December 12, 2024, the Department sent Petitioner a notice of denial appeal, upholding the November 27, 2024, notice. The notice stated specifically:

> After review of the notes submitted by staff for Naomi in the electronic medical record, documentation in CLS notes demonstrates minimal interventions being required during the typical awake or sleeping hours to meet her needs. This is evidenced by consistent and regular documentation of "prompted [redacted] to wash her hand after using the restroom" and "monitor for safety and comfort," in the notes. The support notes from 10/1/24 to current were reviewed and there were few isolated incidents that noted any needs other

[1] Exhibit A, p 32.

> than to wash hands after using the restroom and return to bed. There is consistent documentation from support staff that indicates [redacted] has typical and consistent sleeping hours averaging 10 hours per night. The only documentation of a seizure due to dehydration and overheating occurred in the summer of 2023. Further review of the In-Home Supports assessment completed over the past two years indicates [redacted] is independent in many areas of functioning, including toileting, eating, transferring, bathing. Other areas of support indicate the need for only minimal support including verbal prompts, assistance with meal preparation, assistance with medications, infrequent verbal prompting when she becomes agitated and assistance with money management. She is dependent on staff for transportation to all appointments. She is able to shop independently and select items she prefers. She is able to articulate needs and wants. CLS notes indicate she asks staff for assistance when needed.
>
> The documentation within the support notes from staff demonstrate that the current authorized services of the H2015 CPT code at 53 units may be higher than the current medical necessity for services based on all documentation reviewed in the chart. It may be an option for [redacted] and her guardian to explore residing in a General Adult Foster Care home based on her current needs if staff being present during wake and sleep hours is the preference.[2]

9. On January 2, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Hearing File.)

## 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

[2] Exhibit A, p 37.

> 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.[3]
>
> 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.[4]

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…[5]

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

Here, as discussed above, Petitioner is seeking CLS services and a fiscal intermediary. With respect to the requested services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.4.A. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

[3] 42 CFR 430.0.
[4] 42 CFR 430.10.
[5] 42 USC 1396n(b).

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 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 the Department of Human Services (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.

- 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 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.[6]

While CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[7] 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

[6] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2024, pp 150-151.
[7] *See* 42 CFR 440.230.

- 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.[8]

Here, Petitioner is requesting CLS hours during hours in which Petitioner is sleeping. However, the documentation provided did not reflect the medical necessity requirements for the allocation the Petitioner was seeking.

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

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

The records provided do not show the requested services as being medically necessary. And although Petitioner claims Petitioner cannot sleep and suffers from additional ailments, Petitioner did not provide any additional records of her own to complete the record.

Consequently, with respect to the decision at issue in this case, the Department's decision must be affirmed given the available information and applicable policies.

## DECISION AND ORDER

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

[8] *Id*, at pp14-15.

**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**
Belinda Hawks
MDHHS - BPHASA
320 S. Walnut St., 5th Floor
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