STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON I. BROWN DPA
DIRECTOR

[redacted]
[redacted]
[redacted] MI [redacted]

Date Mailed: June 23, 2025
MOAHR Docket No.: 24-013996
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 video hearing commenced on February 25, 2025, and continued on March 25, 2025, March 27, 2025, and May 6, 2025. The record was then left open until June 10, 2025, for the parties to submit written closing briefs.

[redacted] and [redacted] Petitioner's parents and co-guardians, appeared and testified on Petitioner's behalf.

George Motakis, Fair Hearing Officer, appeared on behalf of Respondent, Lakeshore Regional Entity (LRE), the Prepaid Inpatient Health Plan (PIHP) for Community Mental Health of [redacted] County (CMHOC)(Respondent). Stacie Hamstra, IDD Administrator Lead; Michelle Anguiano, Customer Service Manager; and Anna Bednarek, Chief Operating Officer, appeared as witnesses for Respondent.

EXHIBITS

Petitioner's Exhibits: Exhibits 1-160A

Respondent's Exhibits: Exhibits A-CC

ISSUE

Did Respondent properly deny Petitioner's request for an increase in Community Living Supports (CLS), a unit rate increase for CLS, and an hour and unit rate increase for Supported Employment (SE)[1]?

[1] The request for an additional hour of SE was approved following the internal appeal.

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 who has been receiving services through the Habilitation Supports Waiver (HSW) at CMHOC utilizing self-determination. (Exhibits 2, E; Testimony.)

2. On October 10, 2024, as part of the Individual Plan of Service (IPOS) process, Petitioner requested an approximate 13-hour per week increase in CLS, a unit rate increase for CLS, and an hour and unit rate increase for SE. (Exhibits 2, E; Testimony.)

3. On November 22, 2024, Respondent issued a Notice of Adverse Benefit Determination (NABD) denying the request for an increase in CLS, a unit rate increase for CLS, and an hour and unit rate increase for SE. (Exhibit A; Testimony.) The NABD was poorly written and included incorrect criterion used to make the decision. (*Id.*) As far as the rationale for the denial, the NABD indicated, in relevant part:

> The request to increase the Community Living Supports (CLS) rate and hours is denied. CLS is approved for the same number of hours and rate as last year. The request to increase the Supported Employment rate and hours is denied. Supported Employment is approved for the same hours and rate as last year. . . . The increases to rate and hours for CLS [and] Supported Employment . . . is denied because the current rate and hours of service have ensured [redacted] has attained and maintained "a sufficient level of functioning in order to achieve their goals of community inclusion and participation, independence, recovery or productivity." (Michigan Medicaid Provider Manual, Medical Necessity Definition). Documentation submitted with the service request shows [redacted] is continuing to make progress and learning new skills.
>
> Since self-directed services are being used, the approved funding is flexible and can be moved between approved services as explained in the MDHHS Self-Directed (SD) Services technical requirements. The individual plan of service must reflect these changes. The Michigan Medicaid Provider Manual, section 15 states the beneficiary "chooses to participate in the HSW (Habilitation Supports Waiver) in lieu of ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) services."

> Denial of the additional requested services will not result in the need for ICFAID services. The Community Mental Health of [redacted] County individual budgets for Self-Directed Services Operational Guideline explains "For an individual who is currently self-directing and who has a budget developed based on the process described in the MDHHS Technical Guideline: A) Unless the need changes, the budget should be essentially the same amount from one year to the next. B) CMH will review the agency rate for services and when the agency rate increases, the SD rate will also increase." The agency rate has not increased.
>
> (*Id*.)

4. On December 2, 2024, Petitioner requested an internal appeal. (Exhibits B; C; Testimony.)

5. On December 19, 2024, Respondent issued a Letter of Appeal Denial (LAD), which upheld the original decision. (Exhibit 1, pp 17-22; Exhibit W; Testimony.) The denial indicated, in relevant part:

> Your appeal was not approved for the service(s)/item(s) listed above because:
>
> Request #1: You asked for 13 hours of additional Community Living Supports. Your request and packet was sent out for review by a psychiatrist. The review came back and this was the recommendation:
>
> "In the opinion of this reviewer, based on Michigan Medicaid Provider Manual, the patient does not meet medical necessity criteria for the requested additional 13 hours of CLS. There is no documentation that the patient's current symptoms and behaviors require additional support. The patient is learning new skills. He is making progress with the current services he has in place. The patient is able to achieve the targeted goals of the program with the current services in place. Treatment with services already in place appear appropriate." Howard Burley Jr, MD. Certified in Psychiatry and Addiction Psychiatry by the American Board of Psychiatry and Neurology 12/16/2024
>
> Request #2: You asked for an additional 1 hour per week of supported employment. Your request was reviewed and approved.

> Request #3: You asked for a rate change for your community living support workers. CMHOC uses the average rate as described below to establish an initial self-determination budget. The actual rates used to develop the Self-Determination budget are based on Person-Centered Planning and individual needs and may be different than the average rate. The rate will not be less than our lowest established agency rate. The rate for the cap of the budget will be equitable with the agency rates. Through the person's individual needs and the Person-Centered Planning process we determine what would be a fair market value for an agency rate based on the person's needs.
>
> The rate for Community Living Supports (CLS) provided via a Self-Determination arrangement were computed by adding up the total amount spent on 1:1 CLS provided by contract agencies and dividing that by the number of units provided. The CLS rate . . . is currently $26.96 an hour.
>
> (*Id*., p 17.)

6. On December 27, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's hearing request. (Exhibit 1.)

CONCLUSIONS OF LAW

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

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

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

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

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

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

The RESPONDENT 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, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter*, articulates Medicaid policy for Michigan. It states in relevant part:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
    - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - experimental or investigational in nature; or
    - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

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

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 WAIVER SUPPORTS AND SERVICES

Community Living Supports (CLS) (This is a habilitative service.)

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
    - Meal preparation;
    - Laundry;
    - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
    - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
    - Shopping for food and other necessities of daily living.
- Assisting, supporting and/or training the beneficiary with:
    - Money management;

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

- Reminding, observing, and/or monitoring of medication administration.

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

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

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

> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
>
> *Medicaid Provider Manual*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *October 1, 2024, pp 13-15; 123-125*

Petitioner first argues that the NABD in this matter was not clear and was based on incorrect criterion. (Exhibits 129I, 129C, 128B.) Petitioner then argues that despite the faulty NABD, LRE then colluded with CMHOC to support the denial. (Exhibits 8,121, 121A, 121B.) Petitioner argues that following the internal appeal, Respondent sent the case to PREST, Inc. to obtain a psychiatric report to construct a false narrative to deny Petitioner's request. (Exhibit V.) Petitioner argues that instead of the decision being made by a clinician at LRE, the decision was sent to a psychiatrist at PREST. (Exhibits U, Exhibit 8, p 15.) Petitioner argues that Respondent then misled this tribunal by claiming there was a clinical determination of findings when the decision was really about money and control. Petitioner argues that subpoenaed documents from Respondent demonstrate that cost was the only concern Respondent had with Petitioner's request. (Exhibit 129, p 7.)

Petitioner argues that as an enrollee in the HSW, Petitioner participated in the Person-Centered Planning process to create an individual plan of services using self-direction for participation in meaningful activities with full community integration, productivity, and inclusion and maintaining the least restrictive environment. (Exhibits 157-157A, 147, 10, 149, 2.) Petitioner provided a timeline for the PCP process. (Exhibits G, H, p 27; 2, pp 1-3; 30, 24A, pp 1, 7-8; 140, p 5; 24A, pp 7-8.) Petitioner then notes the general overview/summary of the IPOS:

> [redacted] requires 24/7/365 support due to his disabilities and needs. He lives in his family home with parents (plenary guardians). [redacted] typical active waking hours are 15-17 hours each day. [redacted] participates in an active work-life integrated lifestyle 7 days each week. [redacted] progress particularly the last 6-7 months in IPOS 2023-2024 have shown that he thrives with longer days in the community with work-life integration.

> As a result, [redacted] is working multiple times (paid and/or volunteer) a week regularly, productive, regarded as a valuable community contributor and active participant. The plan has been working and [redacted] is more engaged in more activities and routines as a typical neurotypical individual with his interests thus creating more inclusive settings in the greater community. He requires, on average, 12 hours of CLS/SE daily. At this time, and for this IPOS year, [redacted] is requesting 13,312 units Community Living Supports (which averages 64 hrs/wk) and 624 units of Supported Employment (which averages 3 hrs/wk) to be flexed throughout the plan year. It's important to note that this only averages 9.7 hours per day. His parents are presently willing and able to provide most of [redacted] care. (Exhibit H.)

Petitioner argues that in reviewing this IPOS, [redacted] at CMHOC stopped communicating on the original email chain and started a new email chain titled "budget", demonstrating that Respondent's decision was based only on money, contrary to policy. (Exhibits 55A, 112.) Petitioner also points out that [redacted] complained about the amount of information attached to Petitioner's IPOS and indicated that it would take two weeks to review everything, as opposed to the 48 hours called for in policy. (Exhibit 55A, pp 1-2.) Petitioner notes that [redacted] then notified Petitioner's supports coordinator that Petitioner's services and budget would not be increased from the prior year because there had been no change in his condition. (Exhibit 35A.) Petitioner argues that his supports coordinator tried to justify the requested increases again by emailing Respondent, but the NABD was still issued. (Exhibits 35A, 6, 1A.)

Petitioner argues that Petitioner's requests should be authorized because the family rigorously followed the PCP process, and medical necessity for the increased services was agreed to by the PCP team, including a representative from CMHOC. (Exhibit 2, p 26; Exhibit 3, p 31; Exhibit 146A, p 1.) Petitioner also argues that it is his right to determine the amount, scope and duration of services during the PCP process. (Exhibits 111C, 8.) Petitioner argues that Respondent's denial was arbitrary and will restrict Petitioner's access to participate in the community with full inclusion, resulting in a risk of isolation similar to an institutional setting. Petitioner also points out that the Medicaid Provider Manual prohibits PIHP's from making service determinations based solely on budget. (Exhibit 112, p 15.)

Petitioner also quotes from the IPOS in support of the additional services and budget:

> [redacted] Supports Intensity Scale (SIS) assessment scores indicate that he requires a high level of support for lifelong learning and community participation. He has a history of high risk of regression of skills if not consistently engaged in 1:1 skills-training routines. With his disabilities, [redacted] is at high risk of living a parallel existence and developing feelings of isolation, loneliness, and boredom putting him at risk of mental illness. He needs significant 1:1 support to interact in social settings. Given the right supports and services within the right structure, enables [redacted] to be fully integrated and engaged in the greater community with relationships.

> When [redacted] is kept active daily in a structure with meaningful and fulfilling activities based on his abilities, interests, and strengths, he engages in productive behaviors with less repetitive and ritualistic behaviors, making the symptoms of his autism less debilitating. With his current supports and services, [redacted] continues to expand his interests and activities with full community integration and inclusion.
>
> Due to his IDD, [redacted] will be sedentary if he is not directed to and assisted in meaningful activities throughout the day. His disabilities put him at risk of developing debilitating mental illness (i.e. depression, anxiety) and chronic co-morbidities (i.e. diabetes, heart disease, strokes etc.) that would negatively affect his emotional, behavioral, mental, and physical health, threaten his ability to maintain living in least restrictive environments and shorten his lifespan.
>
> (Exhibit 2, pp 19-21.)

Petitioner then reviewed policy behind the PCP process and medical necessity. (Exhibit 111C, p 1; Exhibit 8, pp 30-31; 157; 104.)

Petitioner further argues that the requests here are reasonable as specialized residential care can cost up to $1,400.00 per day, and with the new CLS, Petitioner's cost is only about $350.00 per day. Petitioner notes that he is in the 87-96 percentile of need for persons in the HSW and needs 24/7/365 care while his cost of care is in the lower third of cost for HSW beneficiaries. (Exhibit 51.)

Regarding the direct care worker (DCW) wage increase, Petitioner indicated that each year his PCP team "costs out" the budget required to fund Petitioner's IPOS. (Exhibits 144, p 10; 2, pp 14-16.) Petitioner argues that Respondent uses zero-based budgeting which is not in compliance with state policy. Petitioner indicated that both the costing out (bottoms-up) model and Respondent's top-down budget model were used and submitted with Petitioner's IPOS. (*Id*.)

Petitioner argues that Respondent arbitrarily discontinued passing through the mandated DCW wage increase despite having done it in past years. (Exhibits 26; 64A.) Petitioner points out that this wage increase is supposed to go directly to the employee unit rates for CLS and SE as called for in the 2023 and 2024 contracts between LRE and MDHHS. (Exhibits 64A; 121, p 108; 63; 3, p 20.) Petitioner points out that on November 1, 2024, an internal email from Beth D. indicates that Respondent had not decided what they were going to do with the DCW wage increase, but that Petitioner's rates would remain the same as the prior year. (Exhibit 140, p 1.) Petitioner argues that per the contracts, Respondent should pass the DCW wage increase to Petitioner's CLS and SE unit rates.

Regarding an increase in the unit rate for inflation, Petitioner argues that Petitioner's budget has not been adjusted for inflation for 4 years. Petitioner argues that if the rates remain the same as last year, he is really getting a cut in payments due to the decreased buying power of the money. Petitioner notes that the CPI from 2022 to this year is about 16% per the Bureau of Labor Statistics but he is only asking for an increase equal to the rate of inflation for last year, or 3.3%. In support, Petitioner points to the settlement in the *Waskul* case. (Exhibit 160A.) Petitioner argues that in requesting an increase in the unit rate based on inflation, he used the same method used in the *Waskul* case.

Petitioner argues that the request for the DCW wage increase and an increase for inflation are very reasonable and based on precedent. Petitioner notes that the cost of the DCW wage increase to Petitioner would only be $836.00 for the year and Respondent has already received this money from the State. Petitioner notes that the cost for the inflation adjustment to the unit rate would be approximately $3,500.00. Petitioner argues that these are small amounts of money compared to the entire budget and will only keep Petitioner's buying power in the same place as last year.

Respondent argues that the documentation submitted showed that Petitioner continued to make progress and learn new skills and that there was no evidence of any needs or behaviors that changed which required an increase in services. Respondent argues that this conclusion was supported by the testimony of its clinician at the hearing, Stacie Hamstra. Respondent points out that Ms. Hamstra reviewed the clinical record including biosocial assessments, supports coordinator progress notes, CLS notes and letters, therapy letters, medical assessments and scripts and concluded that Petitioner's goals and objectives are being met with the services currently in place.

Regarding the request for an increase in the unit rate for CLS and SE, Respondent first points out that the PIHP does not determine the rates that CMHOC utilizes, but that CMHOC was able to explain it's process for determining rates, and this process has been approved by MDHHS. Generally, Respondent points out that this process involves determining an average rate of CLS by adding up the total spent on 1:1 CLS throughout the agency and then dividing that by the units provided. Here, Respondent argues that Petitioner's CLS rate is already well above that average and is actually the highest of all consumers in the self-determination arrangement in [redacted] County, so Petitioner is not entitled to a higher rate.

Regarding applying the DCW wage increase called for in L-Lettter 24-59, Respondent argues that it applied the wage increase to all wage increases equally as those rates were built into the PIHP's capitation rates. Respondent also points out, again, that Petitioner's current CLS rate is already much higher than the average CLS rate in the county.

Regarding application of the *Waskul* settlement to this case to increase the CLS rate based on inflation, Respondent argues that there are no rules that require CMH to follow that settlement agreement, the settlement agreement has not taken effect yet, and Respondent was not a party to the settlement.

Respondent also argues that it is currently involved in litigation regarding the terms of the *Waskul* settlement being included in proposed contracts with MDHHS with four other PIHPs.

Based on the evidence presented, Petitioner has proven, by a preponderance of the evidence, that the CMH erred in denying the request for additional CLS, at least in part. Petitioner has also proved, by a preponderance of the evidence, that Respondent erred in failing to pass on the DCW wage increase to Petitioner's caregivers. However, Petitioner failed to prove, by a preponderance of the evidence, that he was entitled to a unit rate increase for CLS or SE based on inflation.

Regarding CLS, MPM policy provides, "Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation."

Regarding medical necessity, MPM policy provides, in relevant part:

> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - 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.
> - 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;
> - Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
> - Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
> - Documented in the individual plan of service.

Here, Respondent argues that the denial of an increase in CLS was proper because the documentation submitted showed that Petitioner continued to make progress and learn new skills and that there was no evidence of any needs or behaviors that changed which required an increase in services. Respondent also argues that it relied on MDHHS technical guidance, which supports a denial when there is no change in conditions requiring additional services.

However, while the technical guidance would seem to make sense in a practical way, this ALJ sees nothing in published policy that supports such a finding. A thorough review of the above medical necessity criteria from the MPM simply does not support the proposition that a beneficiary's condition must worsen before they can request additional services. Here, a close review of Petitioner's IPOS and the record demonstrates that Petitioner's condition improves with more time in the community. Petitioner needs 1:1 CLS staff to be in the community, so for his condition to continue to improve, he would require additional CLS.

As Respondent points out, pursuant to 42 CFR §440.230(d), an agency may place limits on a service based on medical necessity or utilization control procedures. Here, it appears that additional CLS is medically necessary so Respondent cannot deny services based only on utilization control procedures. However, having carefully reviewed Petitioner's IPOS and the record in this matter, it appears that the goals in Petitioner's IPOS can be met with an increase in CLS of 6.5 hours per week or approximately 1 additional hour per day as opposed to the roughly 13 hours per week that Petitioner requested.

Regarding the DCW wage increase, the policy is entirely clear that this wage increase must be passed on to all direct care workers regardless of their current rate. In fact, the memo from LRE that Respondent included with its closing brief supports this finding. It states, in relevant part:

> This $3.40/hour must be paid in addition to the worker's regular wage, and not simply used to raise staff to a minimum wage threshold. The passthrough must also not be limited to newly hired or minimum wage workers; rather, it must be applied to all qualifying direct care workers, including those already employed at higher wage levels prior to these increases. (*See LRE Memorandum, dated May 8, 2025, Emphasis added*.)

Furthermore, as both parties agree, CMHOC has already received this money as it was included in the capitation rate paid to them by LRE. And, while Respondent's method for determining the CLS agency rate seems appropriate, that has nothing to do with the DCW wage increase. As such, there is no basis in law or policy for Respondent to withhold the DCW wage increase from Petitioner's caregivers even though some of those caregivers are already receiving higher than average wages.

However, regarding Petitioner's request for an increase in his budget based on inflation, Petitioner did not cite any policy to support such an increase. While Petitioner cites the *Waskul* settlement agreement, as Respondent points out, the terms of that agreement are still in litigation. If there is published policy supporting an increase based on inflation, Petitioner failed to provide it to the tribunal.

Therefore, given the above, Respondent improperly denied, in part, Petitioner's request for an increase in CLS. Respondent also improperly failed to pass on the DCW wage increase to Petitioner's caregivers. Respondent properly denied Petitioner's request for an increase to his budget based on inflation.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied, in part, Petitioner's request for an increase in CLS. Respondent also improperly failed to pass on the DCW wage increase to Petitioner's caregivers. Respondent properly denied Petitioner's request for an increase to his budget based on inflation.

IT IS THEREFORE ORDERED that:

- Respondent's decision is **REVERSED IN PART** and **AFFIRMED IN PART.**
- Respondent shall increase Petitioner's CLS by 6.5 hours per week.
- Respondent shall pass on the DCW wage increase to Petitioner's caregivers.
- Petitioner is not entitled to an increase to his budget based on inflation.
- Within 10 days of the receipt of this Order, Respondent shall certify to MOAHR that it has taken action consistent with this decision.

RM/sj

Robert J. Meade
Administrative Law Judge

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

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

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

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

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

Via Electronic Mail:

Petitioner

[redacted]
[redacted] MI [redacted]
[redacted]

Authorized Hearing Representatives

[redacted]
[redacted], MI [redacted]
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