



Date Mailed: March 11, 2025
Docket No.: 25-003126
Case No.: [REDACTED]
Petitioner: [REDACTED]



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এটি একটি গুরুত্বপূর্ণ আইনি উকুমেন্ট। দয়া করে কেউ দ্রাবেজ অনুবাদ করুন।

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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 March 6, 2025. [REDACTED], Petitioner's mother, appeared and testified on Petitioner's behalf.

Heather Woods, Fair Hearing Officer, appeared on behalf of Respondent, Southwest Michigan Behavioral Health, the PIHP for Pivotal. (Respondent or CMH.) Jeremy Franklin, Clinical Quality Specialist and Jarrett Cupp, Chief Compliance Officer, Pivotal, appeared as witnesses for Respondent.

EXHIBITS

Petitioner's Exhibits: Exhibit 1, pp 1-23

Respondent's Exhibits: Exhibit A, pp 1-25

ISSUE

Did the CMH properly authorize Petitioner's Community Living Supports (CLS) hours?

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 CMH under the Habilitation Supports Waiver (HSW). (Exhibit A; Testimony.)
2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A; Testimony.)
3. Pivotal (St. Joseph CMH) is a member of the PIHP regional entity Southwest Michigan Behavioral Health (SWMBH). (Exhibit A; Testimony.)
4. Petitioner lives at home with his family. He receives Community Living Support (CLS), Targeted Case Management, and Medication Review services as authorized by Pivotal. (Exhibit A; Testimony.)
5. On December 20, 2024, CMH issued a Notice of Adverse Benefit Determination (NABD) stating they were partially denying a request for CLS services. The requested amount was 8,320 units for the next year and CMH approved 6,000 units for the year. (Exhibit A, pp 3-5; Testimony.)
6. The NABD states Petitioner used 2,938 units of CLS in the last year, and 4,554 units of CLS the year prior. The notice states that CMH could not find the medical necessity for the full requested amount. (Exhibit A, p 3; Testimony.)
7. On January 8, 2025, Petitioner's guardian filed for a local appeal. After review, the local appeal was upheld. (Exhibit A, pp 6-8; Testimony.) On January 13, 2025, CMH sent a Notice of Appeal Denial (NAD) to Petitioner. (*Id.*) The NAD stated that if the customer runs low on CLS hours, his case holder can request more at that time. (*Id.*)
8. On January 23, 2025, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1.)
9. On January 28, 2025, CMH sent Petitioner an amended NAD to correct an error in the first notice. (Exhibit A, pp 9-11; Testimony.)
10. On February 5, 2025, in preparation for this hearing, SWMBH conducted a utilization and file review. (Exhibit A, pp 12-19; Testimony.)

11. The reviewer noted that Petitioner can share his needs and wants using few word sentences. The reviewer also indicated, "Petitioner requires full physical prompting for all activities of daily living such as: grooming/hygiene needs, dressing, taking medications, transportation, etc." (Exhibit A, p 13; Testimony.)
12. The reviewer also found that Petitioner receives individual CLS supports at home and to attend a day program. Petitioner has support from his mother, father, and grandmother. (Exhibit A, p 14; Testimony.)
13. The reviewer stated that Petitioner has "a history of physical aggression and self-injurious behavior of hitting himself in his forehead when he is frustrated." It was noted that these behaviors have reduced in the past year. (Exhibit A, p 15; Testimony.)
14. The reviewer recommended that the approved 6,000 units of CLS is appropriate based on need and past utilization, but that if the approved units are used up early, more can be requested and reviewed for medical need at that time. (Exhibit A, p 19; Testimony.)

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. 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. See 42 CFR 440.230.

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.

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.

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
Emphasis added*

CMH's Clinical Quality Specialist (CQM) testified that based on the above findings and policy, the decision was made to approve Petitioner for 6000 units of CLS initially, with more available if needed.

Petitioner's mother testified that her main concern was with the limit of 6000 CLS units for the year but had a better understanding now that more CLS could be requested if Petitioner began to run low on the services. Petitioner's mother indicated that the staff where Petitioner attends a day program were concerned with the limitation, which is another reason she filed the appeal. Petitioner's mother noted that CLS staff are doing an amazing job with Petitioner and he is now utilizing almost 40 CLS hours per week because he is no longer in school.

Petitioner bears the burden of proving by a preponderance of the evidence that CMH improperly authorized his CLS hours. Or, in other words, Petitioner must prove that the 8320 units of CLS requested is medically necessary now, as opposed to the 6000 units of CLS authorized. Based on the evidence presented, Petitioner has failed to meet this burden.

As indicated, based on Petitioner's prior CLS usage, and lack of any worsening of Petitioner's condition, plus the fact that Petitioner can request more CLS when needed, the 6000 unit CLS authorization was proper and supported by policy.

Therefore, based on the evidence presented, CMH'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 CMH properly authorized Petitioner's request for CLS.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

RM/sj

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at <https://lrs.michbar.org> or Michigan Legal Help at <https://michiganlegalhelp.org>. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

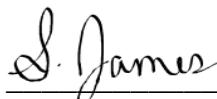
Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOahr-DCH@michigan.gov **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
Michigan Office of Administrative Hearings and Rules
Rehearing/Reconsideration Request
P.O. Box 30639
Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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 11th day of March 2025.



S. James
**Michigan Office of Administrative
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Via Electronic Mail:

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