Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: June 27, 2025
Docket No.: 25-017689
Case No.: [redacted]
Petitioner: [redacted]

[redacted], MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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Case No.: [redacted]
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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 June 26, 2025. [redacted] Petitioner's sister and guardian, appeared and testified on Petitioner's behalf.

Stacy Coleman, Fair Hearing Officer, appeared and testified on behalf of Respondent, Macomb County Community Mental Health. (Respondent or CMH.)

ISSUE

Did the CMH properly authorize 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 who has been receiving services through CMH. (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. Petitioner resides in a private residence. (Exhibit A, p 27; Testimony.) Until recently, Petitioner's mother lived in the home with Petitioner, but Petitioner's mother died shortly before the request for additional CLS was made. (Exhibit A, p 33.)

4. Petitioner is diagnosed with moderate intellectual disability with FSIQ 40, spastic quadriplegic cerebral palsy, cardiomyopathy, acquired hypothyroidism, thyromegaly, thyroid nodule, and seizure disorder. Petitioner has been seizure free for over ten years per care giver report.

Petitioner experiences substantial functional limitations in the areas of self-care, receptive and expressive language skills, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.. (Exhibit A, p 33; Testimony)

5. On February 19, 2025, following her mother's death, Petitioner requested 136.5 hours of CLS from February 16, 2025 through February 28, 2025 and 91 hours of CLS from March 1, 2025 through March 31, 2025. (Exhibit A, pp 1, 26-46; Testimony.)

6. At the time of the above request, Petitioner was also receiving Targeted Case Management from CMH as well as 207.09 hours of Adult Home Help from the Michigan Department of Health and Human Services. (Exhibit A, p 1.) Petitioner also has natural supports available to assist her. (Exhibit A, p 33-34; Testimony.)

7. On March 10, 2025, CMH sent Petitioner an Adverse Benefit Determination indicating that only 50 hours per week of CLS was approved for the period of March 1, 2025 through March 31, 2025 as medically necessary based on the documentation provided. (Exhibit A, pp 19-25; Testimony.) Specifically, the notice indicated, in relevant part:

> Your clinician submitted a request for 91 hours/week of Community Living Support (CLS) for the date range of 03/01/2025-03/31/2025. Based on a review of the documentation in the chart, the medical necessity for this requested volume of CLS is not supported. This request has been brought back down to the previously authorized of 50 hours/week, however, since you are currently approved for this volume of service until 03/31/25, this additional request for CLS has been denied.
>
> (Exhibit A, p 19.)

8. On March 31, 2025, CMH sent Petitioner an Adverse Benefit Determination indicating that only 28 hours per week of CLS was approved for the period of February 16, 2025 through February 28, 2025 as medically necessary based on the documentation provided. (Exhibit A, pp 12-18; Testimony.) Specifically, the notice indicated, in relevant part:

> Your clinician submitted a request for an additional 136.5 hours/authorization of Community Living Support (CLS) for the date range of 02/16/2025-02/28/2025. Based on a review of the documentation, the medical necessity for the requested volume of CLS is not supported.

> This service has been approved for an additional volume of 28 hours/authorization for the date range of 02/16/2025-02/28/2025.
>
> (Exhibit A, p 19.)

9. When the above Adverse Benefit Determinations were issued, there was new documentation missing from Petitioner's records. (Testimony.) Petitioner's guardian testified that her husband died about three days before her mother died and with the state she was in, she was not able to get the documentation to CMH at the time of the request for additional CLS. (*Id*.)

10. Once the above documentation was received by CMH, a new Person Centered Plan meeting was held and Petitioner's CLS was increased to 65 CLS hours per week effective April 1, 2025. (Exhibit A, pp 47-61; Testimony.)

11. On May 14, 2025, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (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. 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; 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2025, pp 13-15

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

The authorization and use of Medicaid funds for any of the BH 1915(i) SPA supports and services, as well as their amount, scope and duration, are dependent upon:

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

Decisions regarding the authorization of a BH 1915(i) SPA service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The BH 1915(i) SPA supports and services are not intended to meet all the

individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in their network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance.

PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Refer to the Behavioral Health Code Charts and Provider Qualifications document for supports and services provider qualifications. The Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

17.4 BH 1915(I) SPA SUPPORTS AND SERVICES

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

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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.
>
> *Medicaid Provider Manual*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *January 1, 2025, pp 148-151*
> *Emphasis added*.

CMH argued that it properly authorized Petitioner's CLS based on the information available to it at the time the decision was made. CMH indicated that once updated information was received, a new authorization of 65 CLS hours per week was approved effective April 1, 2025.

Petitioner's sister indicated that her concern was that [redacted], Petitioner's CLS provider, does a great job and they have not been paid for the additional work they performed in February and March 2025. Petitioner's sister indicated that she feels [redacted] did the work and deserves to be paid retroactively. Petitioner's sister admitted that she did not get the updated documentation to CMH prior to the NABD's being issued but that was due to the fact that her husband died unexpectedly and her mother – also Petitioner's mother – died three days later. Petitioner's sister noted that her husband's death was totally unexpected and he also had a business that she had to deal with.

Petitioner bears the burden of proving by a preponderance of the evidence that 136.5 hours of CLS from February 16, 2025 through February 28, 2025 and 91 hours of CLS from March 1, 2025 through March 31, 2025 were medically necessary and supported by the documentation in Petitioner's records. Based on the evidence presented, Petitioner has failed to prove by a preponderance of the evidence that the additional CLS was supported based on the documentation available to CMH when the decision was made.

As indicated above, BH 1915(I) SPA services are not intended to meet all a consumer's needs and preferences and the CMH must consider its ability to serve other beneficiaries. The CMH must also consider the availability of informal supports.

Here, based on the information available to the CMH at the time the decision was made, it properly denied Petitioner's request for an increase in CLS. Once new information was received, CMH did increase Petitioner's CLS to 65 hours per week. However, there is no allowance in policy for Medicaid to pay for services retroactively that were not authorized. While this ALJ can empathize and sympathize with what Petitioner's sister

went through, there simply is no authority to approve retroactive payment for services that were not authorized at the time they were performed. Furthermore, administrative tribunals do not have equitable jurisdiction unless expressly authorized by statute. *Huron Behavioral Health v Department of Community Health*, 293 Mich App 491 (2011). In other words, this ALJ cannot authorize these payments even if it might seem like the fair thing to do.

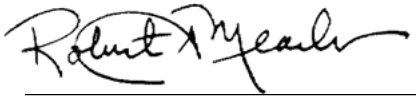
Therefore, based on the evidence presented, CMH's decision was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner's request for 136.5 hours of CLS from February 16, 2025, through February 28, 2025, and 91 hours of CLS from March 1, 2025, through March 31, 2025.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

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.

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