STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-22345 CMH
Case No. [redacted]

Appellant.
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the request for a hearing filed on behalf of Appellant/Petitioner.

After due notice, a hearing was held on [redacted]. Attorney [redacted] appeared on Appellant's behalf. Appellant testified on his own behalf. [redacted], Corporation Counsel, appeared on behalf of Respondent [redacted] County Community Mental Health and Substance Abuse Services/[redacted] County Community Mental Health ("CMH"). [redacted], Utilization Review Coordinator, and [redacted], Appellant's Supports Coordinator, testified as witnesses for the CMH.

Following the hearing, the record was left open at Appellant's representative's request so that she could have the opportunity to review recently submitted evidence and file a closing brief. Respondent's representative also requested an opportunity to file a response to Appellant's closing brief. The record was left open until June 4, 2013.

ISSUE

Did the CMH properly deny Appellant's request that it reauthorize 2,784 units (or 696 hours) of Community Living Supports (CLS) per year and, instead, only authorize 2,088 units (or 522 hours) per year of such services in Appellant's new plan?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old Medicaid beneficiary who was diagnosed with Cerebral Palsy at birth. (Respondent's Exhibit A, pages 4, 33).

2. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH's service area.

3. Appellant has been receiving services through the CMH since at least [redacted]. (Petitioner's Exhibit B, page 1).

4. In his Treatment Plan for the time period of [redacted] to [redacted] Appellant was authorized Community Living Supports (CLS) as part of his services. (Respondent's Exhibit E, pages 1-10).

5. Specifically, Appellant was authorized for two types of CLS: 96 units a year of CLS through [redacted] CMH and 224 units a month of CLS through [redacted]. (Respondent's Exhibit E, pages 4-6).

6. Per the Treatment Plant, the CLS through the [redacted] CMH were to be used during outings at [redacted] baseball games and in support of Appellant's goal of being an active member of his community, as well as the accompanying objectives of increasing his interactions within the community and maintaining important relationships. (Respondent's Exhibit E, page 4).

7. The one-on–one CLS through [redacted] was to be used at least once a month for an After Hours outing and twice a week while Appellant was volunteering at the [redacted] Community Co-op twice a week. That CLS was authorized in support of Appellant' goals of being an active member in his community and volunteering in his community. (Respondent's Exhibit E, pages 4-6).

8. With respect to After Hours outings, Appellant was able to meet his goal of being an active member in the community 7 out of the 12 months of the plan by attending shopping outings or a county fair. (Petitioner's Exhibit D, page 1).

9. Appellant would occasionally use the one-on-one CLS through [redacted] to attend more baseball games. (Respondent's Exhibit A, page 2).

10. Appellant's family and friends also accompany him to baseball games and he attends 10-15 games a year, with his natural supports accompanying and assisting him on most of those occasions. (Petitioner's Exhibit B, page 1).

11. However, throughout the duration of that Treatment Plan, Appellant was unable to consistently volunteer as often as he would have wished or as often as was contemplated by the plan because of a lack of volunteering opportunities at the Co-op. (Respondent's Exhibit A, page 3).

12. On those frequent occasions where Appellant was unable to volunteer, his CLS worker would instead accompany and assist Appellant while Appellant went to lunch or to the movies. (Respondent's Exhibit A, page 2).

13. On [redacted], [redacted], Appellant's supports coordinator, received an e-mail and attached document titled "DDA Budget Reductions". (Petitioner's Exhibit A).

14. The attached document provided, in part, that:

> As you know, the DDA Division has been overspent over the current fiscal year. We have been monitoring to identify where the overspending is occurring and have begun planning for how to address this.
>
> In order to manage within available budgeted funds, the following areas expenditures must be reduced:
>
> * * *
>
> 3. CLS 15-minute units. [Petitioner's Exhibit A, page 2.]

15. The document also provided:

> CLS 15-Minute
>
> The target represents a 25% reduction from current use.
>
> 1. Link individuals with unpaid natural and community supports.
>
> 2. Review all SD arrangements to determine there is appropriate level of services is [sic] being delivered, if any community supports and connections have been made that can reduce paid supports.
>
> 3. A 25% reduction of CLS services for all customers, excluding those who would not be able to live independently without their current level of supports. [Petitioner's Exhibit A, pages 2-3.]

16. [redacted] testified that he never received a mandate to reduce services in all cases or in this case in particular. (Testimony of [redacted]).

17. He also testified that, after he reviewed Appellant's file, he determined that Appellant should receive less CLS in the new authorization as Appellant's CLS were excessive. (Testimony of [redacted]).

18. However, while he determined that a change should be made, [redacted] further testified that it was his supervisor who determined the amount the CLS should be reduced: 25%. (Testimony of [redacted]).

19. On [redacted], a Formal Progress Review was held between Appellant; his guardian; and his supports coordinator. (Respondent's Exhibit A, pages 1-4).

20. During that meeting, [redacted] informed Appellant and Appellant's guardian about the new authorization of CLS hours. (Respondent's Exhibit C, page 2).

21. Scott also "explained his reduction in hours and how it's based on medical necessity." (Respondent's Exhibit C, page 2).

22. They also reviewed Appellant's available CLS hours and how he wished to use them. (Respondent's Exhibit C, page 2).

23. Ultimately, Appellant chose to stop attending After Hours and to use the approved CLS hours to attend baseball games, volunteer, and work one-on-one with his CLS worker. (Respondent's Exhibit C, page 2)

24. The start date for the new Treatment Plan was [redacted]. (Respondent's Exhibit B, page 1).

25. As part of Appellant's services, the CMH again authorized two types of CLS: 72 units a year of CLS through [redacted] CMH and 168 units a month of CLS though [redacted], LLC. (Respondent's Exhibit B, pages 2-6).

26. Both types of CLS were to be used at [redacted] baseball games. (Respondent's Exhibit B, page 4).

27. The CLS though [redacted], LLC was also to be used during Appellant's volunteering periods. (Respondent's Exhibit B, page 6).

28. At the time of review, the supports coordinator informed Appellant that he had a right to appeal the amount of hours authorized and provided Appellant with an Adequate Action Notice of Service Authorization. (Respondent's Exhibit C, page 2).

29. Appellant stated at time that he did not want to appeal. (Respondent's Exhibit C, page 2).

30. The new plan took effect that same day, [redacted]. (Respondent's Exhibit B, page 1).

31. On [redacted], the Michigan Administrative Hearing System (MAHS) received a Request for Hearing in this case. (Respondent's Exhibit D).

32. The Request for Hearing stated: "I disagree with the reduction of my services. My needs have not and did not change." (Respondent's Exhibit D).

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.]

Moreover, 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 Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMHSP contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Here, as a preliminary matter, Appellant's representative argues that Appellant failed to receive any advance notice of a reduction in his services and, consequently, the CMH's action must be reversed.

The Code of Federal Regulations, Chapter 42 addresses a beneficiary's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
>
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
>
> * * *
>
> **§ 431.213 Exceptions from advance notice.**
>
> The agency may mail a notice not later than the date of action if—
>
> (a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

(f) A change in the level of medical care is prescribed by the recipient's physician;

(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

(b) The facts have been verified, if possible, through secondary sources.

It is undisputed that Appellant's new plan and authorization of services took effect on [redacted], the same day he received notice of the amount of CLS hours he was to receive, and that Appellant did not receive advance notice of any change.

However given the definition of an "action" for the applicable regulations, this Administrative Law Judge rejects Appellant's argument that the CMH's decision must be reversed due to a lack of advance notice. An "action" requiring advance notice is defined as

> a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act. [42 CFR 431.201.]

Here, while Appellant was already a recipient of Medicaid benefits, his previous services were only authorized for the time period of [redacted] to [redacted] and, as of [redacted], no services could be provided absent a new authorization of services.

A new authorization of services was made on [redacted] and, while Appellant's services were different from before, there was no termination, suspension, or reduction of the Appellant's services. Instead, Appellant's previous services simply expired as planned and a new plan began.

To the extent Appellant was not re-authorized for all the CLS he was again requesting, the CMH's decision constituted a partial denial or limited authorization of a requested service. Appellant has a right to appeal such a partial denial or limited authorization, as he did in this case, but the CMH was not required to provide advance notice of the new authorization of services as it was not a termination, suspension, or reduction of Appellant's previously authorized services.

The new authorization at issue in this case involved Community Living Supports (CLS). With respect to CLS, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his 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 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 (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS 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 DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff 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 DHS 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 DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. [MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, pages 110-114.]

However, while CLS are Medicaid-covered services, Medicaid beneficiaries are only entitled to medically necessary covered services for which they are eligible and 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. With respect to medical necessity, the MPM, January 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 12-13, provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance

use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

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

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
>
> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
>
> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended

outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 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; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 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 B3 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 his/her 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. MDCH 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.
>
> Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter. [MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, pages 110-111.]

Here, it is undisputed that Appellant needs some CLS and it is only the amount of hours to be authorized that is at issue. As discussed above, while the CMH is willing to authorize 522 hours of CLS per year, Appellant's and his representative are requesting that it reauthorize 696 years of such services, which was the amount he had under his previous plan..

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the request for additional CLS hours. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

CLS are to be used "to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 113). Similarly, B3 supports and services in general are intended to "to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 110).

Here, multiple goals were developed for Appellant in the plan for the time period of [redacted] to [redacted], including goals of Appellant being an active member in his community and volunteering in the community.

However, as described above, Appellant could not or did not fully follow that plan as articulated. For example, while it is undisputed that, as planned, Appellant was using CLS to help him attend [redacted] baseball games, it is also undisputed that

Appellant attended more games than just those allocated through the CLS in his plan. Appellant would sometimes use the CLS allocated for use at the After Hours program to attend baseball games instead. Likewise, Appellant was unable to volunteer as often as he would have liked, given a lack of opportunities, and would instead use the CLS allocated for volunteering assistance as assistance in going shopping or to lunch.

Given how Appellant's services were used and his additional use of natural supports in attending baseball games, it is not even clear that any CLS should be authorized for assisting Appellant in attending baseball games. Appellant attends 10-15 [redacted] games a year, but, even with his use of CLS through both [redacted] County and [redacted] in attending games, friends or family still take him to the majority of those games. B3 supports and services such as CLS "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." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 111). Moreover, decisions regarding the authorization of a B3 supports and services, including the amount of services, "must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 111). Here, given the availability and willingness of Appellant's natural supports to take him to multiple baseball games, it is clear that CLS authorized for assistance in attending baseball games, as well as the amount of CLS used for such assistance, was unnecessary or excessive. Appellant's representative asserts that Appellant is being punished for having natural supports, but the above policy is clear that the CMH must take those natural supports into account.

Additionally, the CLS previously allocated for assistance with volunteering also appear to be excessive. As documented in the PCP review and undisputed by Appellant, Appellant has been unable to consistently volunteer as often as he would have wished or as often as was contemplated in his PCP. Instead, Appellant would use the CLS authorized for assistance with volunteering as assistance in going to lunch or the movies. However, going to lunch or the movies does not help Appellant meet his goal of volunteering in the community. As described above, B3 supports and services such as CLS must, alone or in combination with other services, "reasonably be expected to achieve the goals and intended outcomes identified." (MPM, January 1, 2013, Mental Health/Substance Abuse Chapter, page 110). Here, Appellant's CLS with volunteering cannot reasonably be expected to achieve the goals and intended outcomes identified in the plan because of the lack of volunteering opportunities or other extenuating circumstances. Accordingly, the amount of CLS he was previously authorized was unwarranted

As discussed above, Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying his request for the same amount of CLS previously authorized. Here, Appellant has failed to meet that burden of proof as Appellant's use of natural supports and the unavailability of volunteering opportunities

instead demonstrate that Appellant was previously receiving more CLS than is necessary or appropriate under policy.

Appellant's representative argues that there was no individual assessment of Appellant's need and that the reduction was not based on medical necessity or any other proper reason. In support of that argument, Appellant's representative notes that the CMH's internal memorandum called for a reduction of 25% and that is exactly how much was reduced in this case. Moreover, document attached to the e-mail sent to Appellant's supports coordinator also stated that services "must" be reduced.

However, that memorandum also stated the 25% reduction over the entire budget was only a target and that the goal was still to meet the needs of individuals. Moreover, [redacted] credibly testified that he never received a mandate requiring a 25% reduction and that he independently found that Appellant was previously authorized for too many CLS hours. Similarly, his progress notes at the time document that he explained to Appellant how the reduction was based on necessity. Accordingly, this Administrative Law Judge rejects Appellant's argument and finds that Appellant failed to meet his burden of proof.

This Administrative Law Judge would also note that, after the decision regarding the amount of CLS hours was made, Appellant chose how to allocate his CLS and he expressly chose to continue using CLS for assistance in attending baseball games, which appears unnecessary given his natural supports, and assistance with volunteering, which appears to be unlikely to achieve his intended goals. Nevertheless, the new, specific allocation of CLS is not before this Administrative Law Judge. This Administrative Law Judge's jurisdiction is limited to the negative action that was appealed, i.e. the denial of additional CLS. For the reasons discussed above, this Administrative Law Judge finds that Appellant failed to meet his burden of proof with respect to that denial and the CMH's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request to reauthorize 2,784 units of CLS per year and, instead, only authorized 2,088 units per year such services.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

Docket No. 2013-22345 CMH
Decision and Order

[redacted]

Date Signed: 6/27/2013

Date Mailed: 6/27/2013

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.