STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 14-006774 CMH

[redacted], [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted], an Advocate with [redacted] appeared on behalf of the Appellant. Appellant's mother/guardian [redacted] testified on behalf of the Appellant. [redacted], LLBSW and [redacted] BA, LBSW, Independent Supports Coordinators with [redacted], and [redacted] RN, [redacted] also testified for the Appellant.

[redacted], Fair Hearing Officer for [redacted] the County Community Mental Health Authority for [redacted] County, represented the Department of Community Health (CMH). [redacted]l, Contract Manager/Planner, [redacted], Financial Analyst, [redacted] Developmental Disabilities Division, and [redacted], MSW, [redacted] Utilization Specialist appeared as witnesses for the Department.

ISSUE

Did CMH properly deny Appellant's request for additional 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. Appellant was a [redacted]-year-old Medicaid beneficiary [redacted]) at the time of the hearing. Appellant has been diagnosed with developmental disabilities, including Trisomy–3, severe cognitive impairment, and several medical conditions. (Exhibit B p. 10, Exhibit C pp. 4, 6-7, Exhibit G pp. 2, 5, Exhibit H pp. 1, 4, 6-7and testimony).

2. [redacted] the County Community Mental Health Authority for [redacted] County (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. Appellant receives Medicaid covered services as a person with a developmental disability, including fiscal intermediary services, Supports Coordination, Community Living Supports (CLS), Occupational Therapy Evaluation, and other services through a self-directed arrangement, with [redacted] of the CLS budget delivered as respite services. (Exhibit B p. 9 and testimony).

4. On [redacted], CMH Utilization Management Specialist, completed a review of the CLS Worksheet submitted by [redacted], Appellant's Independent Supports Coordinator, and found that the information submitted did not support the level of care requested. [redacted] found that the "low medical" level of care was supported by the documentation submitted and recommended that the Appellant be approved for CLS services at that level. [redacted] and her supervisor Oom signed the CLS recommendation form on [redacted] and [redacted] respectively and indicated on the form their agreement with [redacted] recommendation of the Low Medical Level of care. (Exhibit E and testimony).

5. On [redacted], MAHS received the Appellant's Request for Hearing. (Exhibit B).

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 Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Network 180 the County Community Mental Health Authority for Kent County (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **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.

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;
- that are experimental or investigational in nature; or
- that are 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*, *Mental Health/Substance Abuse*, July 1, 2014, pp. 12-14].

The *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, July 1, 2014 specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s) [Change Made 7/1/14]

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. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment. **(text added 7/1/14)**

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES [Change Made 7/1/14]

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.

Community Inclusion and Participation

The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).

Independence

"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity

Engaged in activities that result in or lead to maintenance of or increased self sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation. [pp. 117-118].

* * *

17.3.B. COMMUNITY LIVING SUPPORTS [Change Made 7/1/14]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. **(text added 7/1/14)**

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, reminding, 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. (Emphasis added). [pp. 120-121].

In this case, it is undisputed that CLS services are medically necessary for the Appellant. On [redacted], CMH Utilization Specialist, completed a review of the CLS Worksheet along with the Social Work Assessment submitted by [redacted] Appellant's Independent Supports Coordinator, and found that the information submitted did not support the level of care requested. [redacted] found that the "low medical" level of care was supported by the documentation submitted and she recommended that the Appellant be approved for CLS services at that level. [redacted] and her supervisor [redacted] signed the CLS recommendation form on [redacted] and [redacted] respectively and indicated on the form their agreement with Ms. Rublein's recommendation of the "low medical" Level of care. Thereafter, the Appellant's guardian appealed the denial of additional CLS services.

The witnesses for CMH provided credible evidence to show that they properly assessed the Appellant's need for Community Living Supports (CLS). [redacted] utilizes a CLS Worksheet developed over time to ensure that their limited Medicaid budget is fairly and equitably distributed to eligible individuals with intellectual disabilities within their service area. [redacted] established that they have a capitated budget, and according to the policy in the Medicaid Provider Manual quoted above, they must take into account their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these CLS services. According to policy such B3 supports and services are not intended to meet all the individual's needs and preferences.

[redacted] stated that she reviewed the packet of information submitted to the CMH's [redacted] by Appellant's Supports Coordinator on [redacted] Appellant requested [redacted] days of CLS services at the "high medical' level of care delivered on a self-determination basis, and choosing to have [redacted] of the daily rate delivered as respite services. (The daily rate for the "high level' of acre being [redacted] per day, minus the Home Help service daily rate of [redacted] per day, or a total daily rate of [redacted] for CLS services).

[redacted] stated the Appellant's Supports Coordinator had filled out the CLS Worksheet indicating a score of 24 for the Appellant. As a Utilization Specialist, it was [redacted] responsibility to review the proposed scoring on the CLS Worksheet, based upon the supporting documentation submitted, and after her review, [redacted] determined that the Appellant only scored 9 on the CLS Worksheet, and was only eligible for the "low medical" level of care. (The daily rate for the "low medical" level of care being [redacted] minus the Home Help service daily rate of [redacted] per day, or a total daily rate of [redacted] for CLS services).

[redacted] explained why she lowered the Appellant's score on the CLS Worksheet that resulted in a score of 9 indicating a need for the "low medical" level of care for the Appellant rather than the 24 points or the "high medical" level of care suggested by the Appellant's supports coordinator. [redacted] stated for item number 1, respiratory care, Appellant required a low intensity of intervention for 1 point and the frequency of was seldom/monthly for 1 point. [redacted] stated the Appellant had a history of aspiration pneumonia that did not require active intervention so a reduction to a 1 for

intensity and frequency was supported by the documentation. For item number 2, degenerative health condition, no points were given as the same diagnosis was scored by Appellant's supports coordinator under item number 5. For item number 3, tube fed, no points were given as the Appellant is not tube fed. For item number 4, skin care integrity, the intensity of intervention moderate for 2 points, and the frequency was frequently/daily for 3 points. For item 5, other exceptional medical care, Appellant required a low intensity of intervention for 1 point and the frequency of was seldom/monthly for 1 point. The documentation noted the Appellant had seizures and required monitoring and medication for her condition, but no active intervention was required so a reduction to 1 point for both intensity and frequency was supported by the documentation submitted.

[redacted] stated, after the matter was adjourned for [redacted] days, another social work assessment, a nursing assessment, and another CLS Worksheet based on the new information were submitted for a review. [redacted] supervisor, completed the new assessment along with the CLS Worksheet, and [redacted] with U[redacted] [redacted] did the nursing assessment. [redacted] assessment and CLS Worksheet resulted in another recommendation for the 'high medical" level of care based on a recommended score on the worksheet of 23 points. [redacted] again reviewed the supporting documentation and disagreed with [redacted] [redacted] recommendation, finding that the Appellant required only the "low medical level of care based on a score of 9. [redacted] received the nursing assessment a few days later, and revised her score on the CLS Worksheet upwards slightly to a total score of 10, which still indicated the "low medical" level of care. (On item 5, other exceptional medical care, the frequency was increased to sometimes/weekly for 2 points, based on the information in the nursing assessment). [redacted] stated this was the first time the Appellant's case was reviewed by [redacted].

[redacted], Appellant's Supports Coordinator testified she had not gone through the utilization management process before and did not fully understand that she could disagree with [redacted] determination. She said she thought she had to indicate agreement on the form to keep the Appellant's services in place. [redacted] stated she later indicated her disagreement with the proposed reduction and retracted her statement of agreement. (See Exhibits F, pp. 2-3 & Exhibit 1, pp. 1-2). [redacted] asserted in her letter that the Appellant should be scored a 3 on every item for intensity of intervention and frequency except for item 3, as she is not tube fed. This was based on her personal opinion that the Appellant needed constant monitoring in the event that she were to have a seizure, or to insure that she didn't choke or aspirate. [redacted] said Appellant had previously been scored at the "high medical" level of care, and it was her opinion that the Appellant should remain at the "high medical" level.

[redacted] supervisor, [redacted] testified that he completed the second assessment and CLS Worksheet for the Appellant and he did not find there to be any great differences from the Appellant's previous assessments. [redacted] acknowledged there

have been a number of revisions to the CLS profiles. He indicated that he trained on the previous profiles, and although his memory has lessened concerning the training he had received, he believed he completed the scoring on the CLS Worksheet appropriately.

[redacted] with [redacted] testified she completed the nursing assessment that was included in the Appellant's second review. [redacted] indicated the Appellant needs her mouth swabbed several times per day to keep her mouth moist to help prevent tooth decay. She noted the Appellant had cervical polyps removed and had pain requiring use of pain medications. [redacted] said the Appellant was [redacted] prone and also needed to have her bowels assessed daily for possible evacuation. She said the Appellant needs to be properly positioned to avoid aspiration, and she drools a lot. She also had problems with skin break down in the past. Appellant has abrasions on her cornea making her blind, and she has hearing defects. [redacted] said she has a chronic disease of Trisomony-3 which puts the Appellant at risk for cancer in the future and the condition can also affect the Appellant's brain and her heart. [redacted] noted the Appellant does have seizures and needs to be monitored for that condition. [redacted] said to insure safety, the Appellant needs supervision at all times, and requires an emergency plan because she is not able to recognize danger or evacuate on her own.

Appellant's mother testified the Appellant is [redacted] years old and has been receiving Medicaid services through [redacted] since she was [redacted] years old. Appellant's mother said the Appellant's condition has not changed. She said the scoring of the Appellant as needing a "high medical' level of care was consistent with past scoring. Appellant's mother said this was the first time the scoring was changed. Appellant's mother acknowledged that medically the Appellant has some stability, and there has been some improvement in her condition such as with her scoliosis. Appellant's mother said with the change in the scoring Appellant will receive less assistance, and she is already at her maximum with natural supports.

The Appellant bears the burden of proving by a preponderance of the evidence that the additional CLS services are medically necessary. The Appellant's witnesses were given an opportunity to prove why additional CLS services are necessary. The testimony of the Appellant's witnesses and the exhibits admitted at the hearing did not establish medical necessity above and beyond the level of CLS services currently authorized by CMH in accordance with the Code of Federal Regulations (CFR).

The CMH must authorize CLS services in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it authorized CLS for the Appellant at the "low medical' level of services, in addition to the other Medicaid services the Appellant has been authorized to receive. Based upon the totality of the evidence, including the professional opinions of the CMH staff, the CLS services authorized are sufficient to meet the Appellant's needs for CLS services.

It also must be noted that the CLS services are being authorized as B3 services. As stated above in the policy quoted from the Medicaid Provider Manual, B3 supports and services are not intended to meet all the individual's needs and preferences. Also the CMH is required to take into consideration their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

The Appellant has failed to prove by a preponderance of the evidence that additional CLS services are medically necessary. The preponderance of the evidence demonstrates that CMH properly determined that CLS services at the "low medical" level of care are sufficient to meet the Appellant's need for CLS services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that CMH properly denied the Appellant's request for additional Community Living Supports (CLS).

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]
Date Mailed [redacted]

WDB/db

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.