[redacted]

Date Mailed: February 27, 2017
MAHS Docket No.: 16-017962
Agency No.: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on February 2, 2017. [redacted], Petitioner's father, appeared and testified on Petitioner's behalf. [redacted], supports coordinator, and [redacted], supervisor, from [redacted] also testified as witnesses for Petitioner. Attorney [redacted] represented the Respondent, [redacted]. [redacted], testified as a witness for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS) and respite care services?

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 thirty-year-old Medicaid beneficiary who has been diagnosed with mild intellectual disabilities; Bipolar I Disorder, rule out; attention-deficit/hyperactivity disorder NOS; and Major Depressive Disorder. (Exhibit A, pages 14, 22, 38).

2. Due to her diagnoses, Petitioner has substantial limitations in the areas of self-care, learning, self-direction, capacity for independent living, and economic self-sufficiency. (Exhibit A, page 22).

3. Petitioner lives in a private residence with parents and sister. (Exhibit A, pages 14-15).

4. Her father was her legal guardian in the past, but that guardianship ended on January 25, 2012. (Exhibit A, page 23).

5. Petitioner has been receiving services through Respondent and, on October 18, 2016, an Annual Assessment of her needs and services was conducted. (Exhibit A, pages 14-41).

6. At that time, Petitioner was approved for support coordination services; 31 hours of CLS; 50 hours per month of respite care services; and medication reviews. (Exhibit A, pages 23, 46-48; Testimony of Respondent's witness).

7. The CLS and respite care services were utilized through Respondent's Self Determination program. (Exhibit A, page 23).

8. During that assessment it was noted that Petitioner had been stable over the past year, but that she continued to require a moderate amount of support with daily tasks, including prompting and reminders to complete Activities of Daily Living. (Exhibit A, pages 22, 24, 26).

9. It was also noted that "[Petitioner] and her parents report the following challenging behaviors: self-injury (will pick the skin on her face, hands and legs/feet), temper tantrums (will have outbursts when angry, will yell/scream/cry), disruptive behavior (will interrupt, will repeat questions, talk over others), verbal assaults (will swear when upset) and stealing (will take food downstairs or in the bathroom and binge eat)." (Exhibit A, pages 23-24).

10. It was further noted that Petitioner previously received psychiatric services through [redacted] in the past, but they were discontinued because Petitioner and her family were unhappy with their former psychiatrist; Petitioner had not attended any monthly medication reviews since a psychiatric evaluation in May of 2013; and that she did not have a behavior plan. (Exhibit A, pages 23-24, 32, 36).

11. The Annual Assessment recommended that Petitioner receive support coordination services; CLS; respite care services; employment services; psychiatric services; a behavioral assessment; and psychosocial rehabilitative programming. (Exhibit A, page 40).

12. However, it was also specifically noted that Petitioner and her family were not interested in employment services, a behavioral assessment or psychosocial rehabilitative programming. (Exhibit A, page 40).

13. In particular, while Petitioner would benefit from receiving employment services or attending psychosocial rehabilitative programming, her father reported that "she was involved with supportive employment before but had a 'blow out with her job coach'" and "[d]ue to behavioral problems, they are not interested in pursuing at this time." (Exhibit A, page 23).

14. They were interested in a new psychiatrist, but not outpatient counseling or therapy services. (Exhibit A, page 40).

15. On November 2, 20116, a person-centered plan (PCP) meeting was held with respect to Petitioner's needs and services for the upcoming plan year, December 1, 2016 through November 30, 2017. (Exhibit A, page 43).

16. Goal #2 addressed Petitioner's need for CL and it again identified 31 hours per week of such services. (Exhibit A, pages 45-47).

17. Goal #3 addressed Petitioner's need for respite care services and it again identified 50 hours per month of such services. (Exhibit A, page 48).

18. Both CLS and respite care services were again authorized through the self-determination program and the use of fiscal intermediary services. (Exhibit A, pages 49-50).

19. Goal #6 of the PCP included objectives relating to Petitioner agreeing to participate in a psychiatric evaluation within three months if requested and to attend monthly medication reviews, but it was also noted that the goal only remained in Petitioner's PCP in case Petitioner's regular doctor stopped giving her prescriptions. (Exhibit A, page 52).

20. The PCP further identified the recommended employment services, psychiatric services, behavioral assessment and psychosocial rehabilitative programming; while also noting that Petitioner and her family were not interested in them. (Exhibit A, page 53).

21. During the review of Petitioner's proposed PCP, an Access Center reviewer noted in part that: "Annual assessment reports that consumer is now her own guardian, has mild intellectual disability, ADHD and Bipolar Disorder R/O. She appears to require some assistance with ADL's, however, it appear that with prompting, she is able to be independent with these tasks. The amount requested does not appear to be medically necessary for the consumer's functional level while living in the family home." (Exhibit A, page 9).

22. On November 15, 2016, Respondent sent Petitioner written notice that her requests for 31 hours per week of CLS and 50 hours per month of respite

care were denied and that only 25 hours per week of CLS and 27 hours per month of respite care would be approved. (Exhibit A, pages 5-7).

23. The reasons for the decision identified in the notice were that the approved amounts were sufficient to meet the goals in Petitioner's PCP. (Exhibit A, page 5).

24. On December 7, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Petitioner and her representative in this matter regarding Respondent's decision. (Exhibit A, page 11).

25. At some point after the request for hearing was filed, Petitioner's father became her legal guardian again. (Testimony of Petitioner's representative).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…
>
> *42 USC 1396n(b)*

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 (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving CLS and respite care services through Respondent. With respect to such services, the Medicaid Provider Manual (MPM) provides:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> 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 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 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 (MDHHS). CLS may be used for those activities while the beneficiary awaits determination by MDHHS 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 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.

- 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 MDHHS 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 MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

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

* * *

17.3.I. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of

paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

However, while CLS and respite care are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the MPM also 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.

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

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

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - that are experimental or investigational in nature; or

  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

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

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

MPM, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 13-14

Moreover, 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. 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.

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.

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. 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 . . .

MPM, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 125-126

Here, Petitioner requested a reauthorization of the CLS and respite care services that she had been receiving, but Respondent only approved a reduced amount. Specifically, Respondent sent Petitioner written notice that her request for 31 hours per week of CLS and 50 hours per month of respite care was denied and that only 25 hours per week of CLS and 27 hours per month of respite care would be approved.

In support of that decision, Respondent's witness testified that, while a lesser amount of services was approved, the authorized CLS and respite care is adequate to maintain the goals of Petitioner's plan regarding those services. In particular, Respondent's witness testified that other services recommended to Petitioner could better meet some of Petitioner's other needs and her behavioral issues should be addressed in a behavioral plan, but that she and her family rejected those recommendations.

In response, Petitioner's representative described why some of the recommended services were denied, including testimony regarding Petitioner's bad experiences and problems with employment in the past, which still upset her if spoken of; the recent death of the case worker who was coaxing Petitioner into additional services and the significant effect it had on Petitioner; and a warning from past service providers as to what will happen if she comes back and misbehaves. Petitioner's representative also testified that, while there could be more details in the assessment and plan, Petitioner always need to be in sight of someone and, given her natural supports, she needs staff with her 8 hours a day. With respect to Petitioner's natural supports and the need for respite care services, Petitioner's representative further testified that Petitioner's step-mother has health issues; Petitioner's brother, who has compulsive-explosive disorder and who refuses treatment, is back in the home; and Petitioner's representative is the only driver in their house and he has other people in the home to take care of. He also testified that Petitioner needs a legal guardian and that he is again her guardian, with the lapse in the guardianship caused by Petitioner's case worker dropping the ball.

Petitioner's supports coordinator also testified that she was only assigned Petitioner's case a week earlier, but that, based upon her review, the PCP may not clearly reflect Petitioner's circumstances, the reasons she needs the amount of assistance she does, and her goals.

The supervisor from [redacted] further questioned why whether or not Petitioner's utilizes one services should affect her utilization of another.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for additional CLS and respite care services.

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof in this case and that the Respondent's decision must therefore be affirmed. While it does not appear that anything has changed with respect to Petitioner's conditions or needs, Petitioner has still failed to show that the denial of additional hours in her most recent plan was improper given the goals of that plan, the significant amount of services that Petitioner is still authorized for, and the availability of other services. As testified to by Respondent's witness, the recommended employment services, psychiatric services, behavioral assessment, and psychosocial rehabilitative programming; would appear to better address the behavioral concerns identified by Petitioner and her family rather than just generally having someone with her at all times to monitor her. Moreover, while

Petitioner's representative and witnesses questioned why the rejection of other services should affect the authorization of CLS and respite care services when Petitioner needs some services, the above policy provides both that, using criteria for medical necessity, Respondent may deny services for which there exists another appropriate service or support that otherwise satisfies the standards for medically-necessary services and that decisions regarding the authorization of a B3 services such as CLS and respite must take into account Respondent's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services, with B3 supports and services not intended to meet all the individual's needs and preferences as some needs may be better met by other community supports.

Accordingly, taking into account the above policies, the specific goals in Petitioner's plan and the significant amount of services Petitioner is still authorized for, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof with respect to the denial of additional services and that Respondent's decision must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for additional services.

IT IS THEREFORE ORDERED that

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

SK/tm

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

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

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

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

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

Agency Representative

[redacted]

[redacted]

[redacted]

DHHS -Dept Contact

[redacted]

[redacted]