STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 28, 2017
MAHS Docket No.: 17-004818
Agency No.: [redacted]
Petitioner: [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 hearing.

After due notice, a telephone hearing was begun on May 23, 2017. Attorney [redacted] represented Petitioner. [redacted], one of Petitioner's direct care workers, and [redacted], Placement Coordinator at [redacted]., testified as witnesses for Petitioner. Petitioner was present, but did not otherwise participate. Attorney [redacted] represented Respondent [redacted]. [redacted], Access Center Manager, testified as a witness for Respondent.

During the hearing, Respondent submitted one exhibit/evidence packet that was admitted into the record as Exhibit A, pages 1-66. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner'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. Petitioner is a [redacted] Medicaid beneficiary who has been diagnosed with a psychotic disorder, not otherwise specified; mild cognitive impairment; hypothyroidism; gastroesophageal reflux disease; osteoporosis; high cholesterol; asthma; and hearing loss. (Exhibit A, pages 15, 22, 24, 38).

2. Due to her impairments and need for assistance, Petitioner has been receiving supports coordination and CLS staffing through Respondent. (Exhibit A, page 24).

3. Prior to the decision at issue in this case, Petitioner was approved for 44 hours per week of CLS, with [redacted] as the contracted provider. (Exhibit A, page 50; Testimony of Respondent's witness).

4. Petitioner's father-in-law, who she lives with in a private residence and who is her designated power of attorney, also provides limited, informal supports. (Exhibit A, pages 15, 24, 47, 50).

5. On February 7, 2017, Respondent completed an Annual Assessment with respect to Petitioner. (Exhibit A, pages 15-45).

6. During that assessment, it was noted that Petitioner continues to have substantial functional limitations in the areas of learning, self-direction, capacity for independent living, and economic self-sufficiency. (Exhibit A, page 24).

7. It was also noted that Petitioner "continues to require CLS supports to participate in activities of daily living and community activities." (Exhibit A, page 24).

8. In particular, the assessment report provided that Petitioner is able to complete her self-care and some household tasks independently, but that she also requires reminding and supervision; she cannot be left alone for long periods of time; and she is vulnerable in the community because she is trusting of others. (Exhibit A, pages 39-43).

9. On April 5, 2017, a Person-Centered Plan (PCP) meeting was held with respect to Petitioner's needs and services for the upcoming plan year. (Exhibit A, page 47).

10. Petitioner; Petitioner's father-in-law; one of Petitioner's direct care workers; the placement coordinator at [redacted]; and Petitioner's supports coordinator with Respondent; were present for that meeting. (Exhibit A, page 53).

11. Petitioner reported that she would like to continue living where she is and having two staff work with her. (Exhibit A, page 48).

12. Goal #1 of the PCP that was developed provided:

> COMMUNITY LIVING SUPPORTS: Her DPOA/father in law … states on her behalf: "She needs help with a lot of things around here. My health and help are limited." There are also things which [Petitioner's father-in-law] can [sic] do because of his age (94) and him being in a wheelchair. He also states "She also likes to go out to shop. She can't go out by herself. She would get lost."
>
> [Petitioner] states: "I like [redacted]. They help me."

Exhibit A, page 49

13. Specific objectives for Goal #1and the amount of assistance to be authorized in support of each objective were also identified as part of Goal #1. (Exhibit A, pages 49-51).

14. Objective A was for assistance with Petitioner's morning routine, including brushing teeth, brushing hair, getting dressed, applying deodorant and making the bed; and 2 hours and 30 minutes per week of such services were to be authorized. (Exhibit A, page 49).

15. Objective B was for assistance with Petitioner taking a shower, including gathering items for the shower, brushing teeth, brushing hair, getting dressed, applying deodorant, making the bed, and cleaning up the shower; and 8 hours per week of such assistance were to authorized. (Exhibit A, page 49).

16. Objective C was for assistance with Petitioner's participation in breakfast and lunch preparation; and 3.5 hours per week of such assistance were to be authorized. (Exhibit A, page 49).

17. Objective D was for assistance with Petitioner setting up her pill box; and 15 minutes per week of such assistance were to be authorized. (Exhibit A, page 49).

18. Objective E was for assistance with Petitioner taking her medications; and 1 hour and 45 minutes of such assistance were to be authorized. (Exhibit A, page 49).

19. Objective F was for assistance with Petitioner completing daily household chores; and 7 hours per week of such assistance were to be authorized. (Exhibit A, page 49).

20. Objective G was for assistance with Petitioner in planning healthy meals and making healthy food choices, including preparing a grocery list, shopping for the needed groceries; and putting groceries and supplies away; and 4 hours per week of such assistance were to be authorized. (Exhibit A, page 49).

21. Objective H was for assistance with Petitioner washing her hands after using the bathroom or preparing food; and 1 hour and 45 minutes per week of such assistance were to be authorized. (Exhibit A, pages 49-50).

22. Objective I was for assistance with Petitioner in participating in community inclusion activities of her choosing; and 17.5 hours per week of such services were to be authorized. (Exhibit A, page 50).

23. Objectives J and K were for assistance with Petitioner in displaying appropriate social interactions and successfully completing money transactions while out in the community; with no separate time authorized in support of that objective. (Exhibit A, page 50).

24. Objective L was for assistance in Petitioner reviewing emergency procedures; and 30 minutes per week of such assistance were to be authorized. (Exhibit A, page 50).

25. Overall, 44 hours per week of CLS was to be authorized, with services to be provided 8:30 a.m. to 4:30 p.m. on Mondays, Wednesdays, Thursdays and Fridays, and 9:30 a.m. to 1:30 p.m. on Tuesdays, Saturdays and Sundays. (Exhibit A, page 51).

26. On April 6, 2017, Respondent sent Petitioner written notice that the request for 176 units/44 hours per week of CLS was denied and that only 20 units/5 hours per day of such services would be approved. (Exhibit A, pages 9-11).

27. After stating that the CLS had been requested in an improper per diem format, the notice also identified the following Reason for Action: “Amount reduced to reflect clinically appropriate level based on review of all relevant documentation in the medical record.” (Exhibit A, page 9).

28. On April 18, 2017, the Michigan Administrative Hearing System received the request for hearing filed in this matter regarding that decision. (Exhibit A, page 13).

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's CLS through Respondent is in dispute in this case. With respect to such services, the applicable version of 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.

MPM, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Pages 128-129

Moreover, while CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *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, Respondent denied Petitioner's request for reauthorization of her past CLS services, 44 hours per week, and instead approved a reduced amount of such services, 35 hours per week.

In support of that decision, Respondent's Access Center Manager testified that, while she did not review the original request or make the decision to deny it, she has reviewed the case and concurs with the decision. In particular, she testified that the additional CLS hours were not necessary because several of the objectives in Petitioner's PCP are duplicative of each other, including Objectives A and B, and Objectives C and G, and that those objectives should be combined for a lesser amount of services. She also testified that the hours to be authorized in support of another objective, Objective I were excessive, though she could not say exactly why they were excessive other than testifying that she would have asked if Petitioner does something in the community every day.

Respondent's Access Center Manager further testified that she does not know if the reasons for denial she identified were the reasons used by the reviewing clinician, but that they all follow a similar, unwritten procedure. She also testified that she assumes Petitioner's natural supports were considered, but that such supports were not the basis for the action because the PCP expressly states that Petitioner's sole natural support does not assist her with CLS activities.

In response, one of Petitioner's direct care workers testified that she simply follows the PCP as written and she is not allowed to decide if parts of the plan are duplicative. She also testified that there would be an incident report made if the plan was not followed and that she feels the old amount of CLS that was approved was sufficient.

The Placement Coordinator at the agency who provides Petitioner's CLS testified that Petitioner's care providers have to follow what is exactly what is in the plan of service, regardless of the hours that are approved, and that an incident report would be made if the plan is not followed, again regardless of what amount is authorized. She also testified regarding the very thin margins used by the provider agency and that she is unsure if it, or any other agency, could continue to provide staffing at the reduced amount of hours.

Petitioner's representative similarly argued that, by arbitrarily cutting Petitioner's CLS hours without changing the PCP as written and submitted, Respondent has made it economically nonviable for any staffing agency as it will either cause a recipient rights

violation, by only providing care during the hours authorized by Respondent, or lose money, by following the plan. Petitioner's representative also argued that, given the above situation, the 5 hours per day constitutes an effective denial.

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

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has met failed to meet that burden of proof and that the Respondent's decision must therefore be affirmed.

While it does not appear that anything has significantly 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. Petitioner is still authorized for a significant amount of CLS and, as testified to by Respondent's witness, some of the objectives identified as part of Goal #1 of Petitioner's PCP are clearly duplicative or overlapping. For example, the same specific tasks are expressly identified as the areas for assistance in both Objectives A and B.

Moreover, while Respondent's witness could not adequately explain why she believed that the hours requested for assistance with community inclusion were excessive, Petitioner also offered no evidence as to why they are necessary and the mere fact that Petitioner received such hours in the past is insufficient on its own to meet Petitioner's burden of proof.

Petitioner's representative did argue that, because the care provider agency is bound by the plan as written, the approval of a lesser amount of services is effectively a denial of services, as the care provider agency would be taking a loss if it followed the plan and will therefore stop providing services instead. However, the undersigned Administrative Law Judge does not find that argument to be persuasive. Petitioner's representative's argument and the testimony of the employees of the care provider agency fail to demonstrate that the additional services that were requested are necessary and the suggestion that All-Ways Care may stop providing services to Petitioner at some point in no way shows that no provider would agree to provide five hours per day of services, especially where the plan can be amended to reflect the actual hours that were authorized.

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 her burden of proof with respect to the denial of additional CLS 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 CLS 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

Counsel for Respondent

[redacted]

Petitioner

[redacted]

DHHS -Dept Contact

[redacted]

DHHS-Location Contact

[redacted]

Counsel for Petitioner

[redacted]