STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[redacted]

Date Mailed: August 15, 2024
MOAHR Docket No.: 24-006353
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Steven Kibit**

## DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on July 23, 2024. [redacted] Petitioner's mother/legal guardian, appeared and testified on Petitioner's behalf. Petitioner and Jameson Jasper, Petitioner's Supports Coordinator at Network 180, also testified as witnesses for Petitioner. George Motakis, Fair Hearing Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Julie Minor, a Utilization Review Specialist at Network 180, and Michelle Anguiano, a Customer Services Manager at Respondent, also testified as witnesses for Respondent.

During the hearing, the following exhibits were admitted into the record without objection:

Exhibit A: Notice of Adverse Benefit Determination and Appeal Request

Exhibit B: Appeal Packet

Exhibit C: Notice of Receipt of Appeal

Exhibit D: Notice of Appeal Denial

Exhibit E: Appeal Summary Report

Exhibit F: Request for Hearing

Exhibit G: Letter from Petitioner's representative

Exhibit H: Notice of Hearing

Exhibit I: Licensing Rule 400.14302

## ISSUE

Did Respondent properly decide to reduce Petitioner's 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-three (33) year-old Medicaid beneficiary who has been diagnosed with a mild intellectual disability; attention-deficit/hyperactivity disorder; kleptomania; fetishistic disorder; a mood disorder; and sexual abuse social/emotional development. (Exhibit B, pages 12, 77; Exhibit G, page 1).

2. He has a legal guardian. (Exhibit F, page 5)

3. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP). (Exhibit A, page 12; Testimony of Respondent's representative).

4. On March 2, 2020, after unsuccessful placements in other Adult Foster Care (AFC) homes, Petitioner moved into the Paragon House, a 24-hour licensed setting, operated by Hope Network West Michigan ("Hope Network"). (Exhibit B, page 59; Exhibit F, pages 3; Testimony of Petitioner's representative).

5. As part of Petitioner's services, Network 180 then authorized community living supports (CLS) and personal care services through Hope Network at a Base Residential Rate Level of Care (LOC). (Exhibit E, pages 1-2).

6. A Base Residential Rate LOC is a per diem rate paid for more restrictive services with higher staffing than lower levels of care, such as Light Residential. (Testimony of Utilization Review Specialist; Testimony of Supports Coordinator).

7. Petitioner also had a specific Behavior Treatment Plan, developed in part with Sparks Behavioral Services, to address his issues with hygiene refusals, stealing, and risky social boundaries. (Exhibit B, pages 13-40).

8. In a Behavioral Assessment completed on March 8, 2023, Sparks Behavioral Services found:

> **SUMMARY AND CONCLUSIONS**
> Over the past treatment period, [Petitioner] has met behavioral objectives for theft and elopement. Due to this, a focus of the following behavior plan will be to decrease community supervision. [Petitioner's] identified target behaviors are hygiene refusals and risky social boundaries. [Petitioner] has engaged in risky social boundaries that have potentially financially exploited him when he was purchasing prepaid debit cards for a woman he met online and never met in person.
>
> **TREATMENT AND RECOMMENDATIONS**
> It is recommended that all of [Petitioner's] caregivers are familiar with and able to implement his behavior treatment plan consistently and correctly. Restrictive strategies should be faded slowly with lots of oversight to prevent regression

*Exhibit B, page 45*

9. On January 8, 2024, Petitioner's Supports Coordinator completed a Biopsychosocial Assessment. (Exhibit B, pages 56-78).

10. During that assessment, he noted that Petitioner was doing well overall; he was comfortable and happy in his current home; and that he had been working since 2022, with a recent interview for another job. (Exhibit B, pages 63-64, 77).

11. He also found that Petitioner's kleptomania and fetishistic disorder were in remission, and that Petitioner had not had an occurrence with theft in over a year. (Exhibit B, pages 76-77)

12. He further found that Petitioner cannot live on his own and still needs to be monitored outside of the home due to a risk of people taking advantage of him, but that Petitioner mostly did well with being safe and that his elopement frequency was about once a month or less. (Exhibit B, pages 60, 75).

13. The Biopsychosocial Assessment also provided that Petitioner was independent in bathing, dressing, and grooming, with only "infrequent reminders to ensure that he is grooming regularly and doing an adequate job." (Exhibit B, page 74).

14. On January 17, 2024, an Individual Plan of Service (IPOS) Meeting was held with respect to the upcoming plan year, *i.e.,* March 1, 2024 to February 28, 2025. (Exhibit B, pages 81-91).

15. In the report issued following that meeting, Petitioner's Supports Coordinator indicated that Petitioner was independent in personal care skills, with infrequent reminders for grooming; he requires assistance with domestic skills, including meal planning and preparation, laundry, household cleaning, and money management; and he requires assistance with community and safety skills. (Exhibit B, pages 81-83).

16. Petitioner's primary behavioral concern was identified as theft, but addressing issues with theft was no longer part of Petitioner's goals. (Exhibit A, pages 83, 85-89).

17. Another behavioral concern was identified as inappropriate boundaries, with Petitioner having improved from several hundred tracked events in that area to under fifty such events during 2023, albeit with a significant increase in first month in 2024 due to increased opportunity to spend time with family. (Exhibit A, page 84).

18. The identified goals in the IPOS involved Petitioner improving his socialization skills; independence; mental health and well-being; personal care skills; and behavioral health skills. (Exhibit B, pages 85-99).

19. Following that IPOS Meeting, Petitioner's Supports Coordinator submitted a request on Petitioner's behalf to Network 180 for a reauthorization of services, including a Base Residential Rate LOC at Paragon House. (Testimony of Supports Coordinator).

20. On February 5, 2024, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that it was denying a request for the Base Residential Rate LOC. (Exhibit A, pages 2-10).

21. In part, that notice stated:

> **This action is based on the following:**
>
> The clinical documentation provided does not establish medical necessity.

> You have Base Behavior rate for PC and CLS to help with behaviors like taking things that don't belong to you. You have been doing very well with this for a long time, and you no longer need Base Rate. Your Supports Coordinator should ask for Light Residential rate. Please contact the Supports Coordinator with questions. This is based on the Michigan Medicaid Provider Manual and Network 180 PC/CLS Guidelines.

*Exhibit A, page 2*

22. On March 1, 2024, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 11; Exhibit C, pages 1-5).

23. In that Internal Appeal, Petitioner's representative wrote that she did not want a rate reduction because the staff at Paragon House do a lot for Petitioner in keeping him busy and out of trouble, and that she did not want Petitioner to lose his home placement due to his job, church, and community activities. (Exhibit A, page 11).

24. On March 14, 2024, Respondent sent Petitioner a Notice of Appeal Decision stating that his Internal Appeal had been denied and the Adverse Benefit Determination upheld. (Exhibit D, pages 1-6).

25. With respect to the reason for that decision, the Notice of Appeal Decision stated in part:

> You would like to continue with base rate for your personal care and community living supports. Your case was reviewed and you have done very well over the past year with your target behaviors, you have had almost no incidents in the past year in two target behaviors. Your current behavior plan can be managed at the light rate for personal care and community living supports.

*Exhibit D, page 1*

26. On May 28, 2024, MOAHR received the request for hearing filed in this matter. (Exhibit F, pages 1-10).

27. As part of that request for hearing, Petitioner included a letter from Hope Network stating in part:

> [Petitioner] has lived at Hope Network's Paragon Home since his admission on March 2, 2020 and, prior to that, at another home within [Hope Network's] residential system since November 2018. During this time, [Petitioner] has increased and maintained progress on his treatment goals leading to stabilization of symptoms due to the supports he has been receiving.
>
> Network 180 has determined that [Petitioner's] needs are best served in a lower level of care than Paragon provides; therefore, Hope Network is unable to support continued placement in this program.
>
> * * *
>
> Hope Network will continue to collaborate with Network 180 on finding alternative placement for [Petitioner] and appreciates the opportunity to have worked together on this case.

*Exhibit F, page 3*

## 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 authorized for community living supports (CLS) and personal care services through Respondent and Network 180, with the services paid to the provider Hope Network at a per diem Base Residential Rate Level of Care (LOC).

With respect to such services specifically, and services in general, the applicable version of the Medicaid Provider Manual (MPM) states in part:

## SECTION 2 – PROGRAM REQUIREMENTS

### 2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/1915(i) SPA) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)

- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.

- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).

- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which they are entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of their plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or their guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and their guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

* * *

## 2.3 LOCATION OF SERVICE

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

* * *

## 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.

* * *

## SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

### 11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;

- Transferring (between bed, chair, wheelchair, and/or stretcher);

- Ambulation; and

- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks themself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

* * *

**17.4.A. COMMUNITY LIVING SUPPORTS (CLS)**

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

  - meal preparation

  - laundry

  - routine, seasonal, and heavy household care and maintenance

  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

  - shopping for food and other necessities of daily

living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- CLS staff providing assistance, support and/or training with activities such as:

  - money management

  - non-medical care (not requiring nurse or physician intervention)

  - socialization and relationship building

  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving CLS.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help services when the beneficiary's need for this assistance has been officially determined to exceed the allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary. These supports may serve to reinforce skills

> or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.
>
> *MPM, January 1, 2024 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 9-10, 13-15, 90, 150-152*

Here, as discussed above, Respondent has decided to reduce Petitioner's services and only authorize his CLS and personal care services at a lower level of care pursuant to the above policies and on the basis that the higher, more restrictive level of care is not medically necessary. Petitioner then appealed that decision.

In appealing the decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has not met that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner has lived in his current foster care home, and he has received his services there at the Base Residential Rate LOC since March of 2020, and it is undisputed that he has made significant progress in his targeted goals and issues since that time. He has consistently remained employed and Respondent's progress notes and assessments reflect improvement, particularly in his grooming/hygiene, his past history with theft, and his issues with social boundaries. Petitioner's guardian's testimony also confirmed that improvement and Petitioner's providers have further documented Petitioner's development, with Hope Network, the provider assisting Petitioner with CLS and personal care services, specifically referring to Petitioner's progress and stabilization in the letter submitted by Petitioner as part of the request for hearing.

Moreover, per policy, Respondent may deny services 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. Here, it is undisputed that CLS and personal care services based on the Light Residential rate are less restrictive than services through the Base Residential Rate LOC; and, given Petitioner's significant progress and stabilization, the record demonstrates both that the reduced services through the Light Residential rate can satisfy the standards for medically necessary services for Petitioner and that the reduction in Petitioner's services from the Base Residential Rate LOC to the Light Residential rate is proper.

Petitioner's guardian testified that they do not want Petitioner's services to change given his improvement, with Petitioner's staff and the services responsible for the success and stabilization that he has had. However, while understandable, Petitioner's guardian's testimony does not change the applicable policy and its provision that Respondent may deny services for which there exists other appropriate and less-restrictive services or settings that otherwise meet Petitioner's needs. Petitioner's past services have met his needs, but that alone is insufficient to meet Petitioner's burden and the record in this case reflects both that Petitioner has improved to such a point that a less restrictive level of care can meet Petitioner's need and that a reduction in services is appropriate.

Moreover, while Petitioner's Supports Coordinator testified that his reports regarding Petitioner's behaviors were not completely accurate because he had not received updated reports from Petitioner's providers at the time he assessed Petitioner and developed the new IPOS, no supplement records have been provided and, regardless, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

To the extent that Petitioner's guardian has additional information to provide or Petitioner's circumstances change, then Petitioner's guardian can always request additional services in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

## DECISION AND ORDER

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

**IT IS THEREFORE ORDERED** that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sj

**Steven Kibit**
Administrative Law Judge

**NOTICE OF APPEAL**: Petitioner 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

**PROOF OF SERVICE**

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 15th day of August 2024.

S. James

S. James
**Michigan Office of Administrative Hearings and Rules**

**Via Electronic Mail:**

**DHHS Department Contact**
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**Via Electronic & First Class Mail:**

**Petitioner**
[redacted]

**Authorized Hearing Representative**
[redacted]