STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-20684 CMH
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted], the Appellant's mother represented the minor Appellant. [redacted] (CMH), represented the CMHSP. [redacted] for the CMH was present as a witness on behalf of the Department of Community Health contracted PIHP. [redacted], was present as a witness. [redacted] for the Appellant, was present as a witness.

ISSUE I

Did the Department properly propose reduction of Community Living Supports (CLS) to the Appellant?

ISSUE II

Did the Department properly propose reduction of respite services to the Appellant?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] year-old Medicaid beneficiary. He resides with his mother in his family home.

2. The Appellant is an only child. He does not have any natural supports outside of those provided by his mother.

3. The Appellant is diagnosed with Autism, cognitive impairment, seizure disorder and asthma.

4. The Appellant is prescribed multiple medications, including Carbtrol, Catapres, Trazadone, Trileptal and Risperdal. He attends school and receives special education services.

5. The Appellant has an I.Q of approximately [redacted] There is disagreement between the parties regarding his abilities.

6. The Appellant has been receiving Community Living Supports services from a CMH contractor.

7. The Appellant's mother asserts his medical condition results in a medical need for constant monitoring and supervision of the Appellant beyond that which is necessary for a typical [redacted] year old. He does exhibit aggression and is unable to attend to his own needs or make appropriate safety decisions for himself.

8. The Appellant's mother is physically ill and unable to provide for her son's physical needs. She asserts she is unable to provide the supervision and guidance he requires due to her multiple medical conditions.

9. The evidence of record does not demonstrate daily physical interventions or redirection of the Appellant by his CLS worker or mother.

10. The Appellant is currently receiving 7.5 hours per day Community Living Supports. The Department seeks to reduce the authorization to three (3) hours per day.

11. The Appellant is authorized to receive 12 hours per day respite. The Department seeks to reduce the authorization to 1.61 per day (45 hours per month)

12. The Appellant seeks to have 24 hours per day, seven (7) days per week supports from CMH, in the form of CLS and respite services.

13. The Department has determined it is not medically necessary to authorize CLS and respite hours in the amount the Appellant has received in the past. The Department sent a Negative Action Notice on or about [redacted].

14. The Appellant, through his mother, disagrees with the proposed reduction in the service hours, thus requested a formal, administrative hearing.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Macomb County CMH, a Prepaid Inpatient Health Plan (PIHP), contracts with the Michigan Department of Community Health to provide 1915(b) specialty mental health services. The PIHP's contract with the Department requires that all services paid for with Medicaid funds must be medically necessary. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

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

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

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

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

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

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

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that

beneficiary, unsuccessful or cannot be safely provided; and

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

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

Deny services that are:

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

The Medicaid Provider Manual specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified

in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

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 mental retardation)

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 his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service. Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.3.B. COMMUNITY LIVING SUPPORTS

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

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry

- routine, seasonal, and heavy household care and maintenance
- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.
- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these

activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

17.3.F. FAMILY SUPPORT AND TRAINING

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service. Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
- Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident

and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

17.3.J. RESPITE CARE SERVICES

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary caregiver (e.g., family members and/or adult family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide 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. 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

Respite care may not be provided in:

- day program settings

- ICF/MRs, 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.

Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: April 1, 2010

The Department's agent asserts that the Appellant only requires three (3) hours a day of CLS services. This is a reduction of services authorization from 7.5 per day to the current proposal. The witness for the Department asserts the documentation submitted does not support authorization of CLS services in excess of the three (3) hour per day proposal. The Appellant is said to be "functioning well". It is further asserted he would continue to do so with the provision of supports and services as proposed by the Department. There is no improvement in condition cited or any change in circumstance. It was asserted it is not medically necessary to authorize additional CLS services beyond three (3) hours per day to address the Appellant's needs. It was further asserted the current authorization of 7.5 hours appeared to be a response to the Appellant's mother's medical condition rather than the Appellant's documented needs. In response to the assertion from the Appellant's mother that her medical condition renders unable to provide the supervision, guidance and physical care normally provided by a parent, the Department cites Medicaid provider manual statement that "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". While the Department witness did not directly assert the Appellant's mother has the ability to supervise and monitor her own child, it is implicit in the Department's position that it is not only addressed in policy but that she is able to also because it was asserted the Appellant is much like a typical [redacted] (at the time of hearing) adolescent. As an [redacted] or [redacted] year old verbal supervision and monitoring would be the primary care taking needs, along with upkeep of the home, meal preparation and laundry. The homemaking duties are addressed by another program, thus not at issue in this hearing. The Department witness asserted policy requires a parent to provide what they normally would to their disabled child, despite the child's qualification for program benefits, thus there is no need for CLS in excess of 3 hours per day.

One of the Appellant's CLS workers was present and provided testimony to refute the claim from the Department witness that the Appellant functions much the same as any [redacted] year

old boy would. He had been working with the Appellant for two (2) years as of the time of hearing. He said the Appellant is functioning at about the same level as a [redacted] year old. He stated he is much like a [redacted]. He cannot make appropriate safety decisions for himself and would be at risk if unsupervised.

This ALJ reviewed the documentation and testimony submitted by all parties. The documentation submitted by the agency requesting the authorization from the CMH is not specific regarding the Appellant's functional status, thus it is not hard to see why the Department's witness could not find justification in the documents themselves for the services requested. The Annual Assessment and Progress Notes provided the Department witness were cited by the Department witness and contained no description of the Appellant's functional abilities. However, there is no documentation that the Appellant is routinely physically aggressive or lacks functional abilities of other children his age with appropriate supervision and monitoring. There is no documentation that the Appellant has daily physical interventions or constant need for hands on authority to maintain living in the least restrictive environment (his family residence). The testimony that he requires constant supervision and monitoring is found credible, however, the need for supervision and monitoring is materially different than a need for constant or even daily physical interventions. Evidencing a need for supervision and monitoring is not the same as evidencing that the Appellant's mother is unable to do it or that it is appropriate to authorize CLS in place of parenting. Perhaps there is more documentation in an earlier assessment and the lack of evidence of a change or significant improvement in the Appellant's condition would signify a need for services to continue at the same level. However, no such evidence is in the record for the purposes of this hearing. Although the lack of current documentation submitted by the contracted agency is apparent, the reality of the Appellant's circumstance does not escape notice from this ALJ. Two years of direct, hands on experience is relevant. This witness provided credible testimony the Appellant functions much like a [redacted] People with his functional abilities are not left unsupervised for any part of any day. In light of the credible testimony that the Appellant requires constant supervision and monitoring, this ALJ sought authority in policy for authorizing CLS as requested and for the reasons requested by the Appellant.

This ALJ searched the Medicaid Provider Manual for policy addressing the circumstances faced by the Appellant and his family. In this case, it is uncontested the Appellant is not enrolled in any Children's Waiver Services or HAB supports waiver. He is not qualified for them. Policy addressing the actual need for the Appellant to be supervised is not found. This ALJ does not agree with the assertion from [redacted] that the Appellant does not have a need for supervision and monitoring in excess of a typical [redacted] (now [redacted] year old boy, however, no policy was found that would support a determination that CLS can be authorized to supplant the care normally provided by a parent. Even the testimony the

Appellant has the functional status much like a [redacted] does not establish a medical need for near 24hour a day provision of supports. Nor did the Appellant's evidence cite to policy supporting authorization of extraordinary CLS to compensate for parental illness.

It is uncontested that the Appellant's mother is medically unable to provide the normal amount of physical care expected of her due to her medical condition, however, there is no evidence to persuade this ALJ that the supervision and monitoring needed is beyond the medical capability of the Appellant's mother. If she lacks the authority to verbally supervise and monitor her son, she may have a parenting issue. She may request family training to address this need, however, CLS is not a substitute for the normal parenting provided, even in the Appellant's circumstances. This ALJ is sympathetic to the circumstances faced by Appellant and his mother. It is understood the Appellant's mother is unable to physically care for the Appellant, however, the CMH is correct in asserting there is no documentation to support a determination that the Appellant requires 7.5 hours per day CLS. The Appellant has not evidenced a medical need for the authorization she requests. She has not met her burden of proof.

The assertion the Appellant and his mother require 12 hours per day of respite care is not supported by the evidence of record at this time. The purpose of respite is to provide relieve an unpaid caretaker. While the reduction in the CLS authorized will result in the Appellant's mother providing much more direct care of her son than in the past, to date, it is not established exactly what level of respite is going to be necessary to reasonably achieve the goal of temporary relief. The testimony provided by the Appellant's witness is that the Appellant does not sleep through the night, thus requires supervision throughout the night as well as day. There may be a need for additional respite hours to be authorized in the future due to the fact that the Appellant's mother may not get uninterrupted sleep. This would be consistent with goals and purposes of respite, to provide an unpaid caretaker opportunity to have uninterrupted sleep. However, it is not evidenced at this time that the authorization being provided is inadequate to provide that in some measure already. The Appellant's mother has not provided any evidence demonstrating a need for 12 hours per day of respite authorization, despite the uncontested evidence of her own medical condition. While she may have good reason to make a request for increase in the future, as it stands now, there is no record to support an authorization in excess of what has been proposed. Given the evidence of record, the proposed authorization of 1.61 hours per day may be adequate to meet the goals and purposes of respite in this case.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, find the proposed authorization of three (3) hours per day CLS and 1.61 hours per day respite are adequate to meet the medical needs of the Appellant.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 05/12/2010

***** NOTICE *****

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