STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted]

Docket No. 2012-32599 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*. and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] Student Attorney [redacted] and Supervising [redacted] represented Appellant. Assistant Attorney General [redacted] represented the Department of Community Health. [redacted] testified as a witness for Appellant and [redacted], Nurse Consultant for Children's Special Care Services, testified for the Department. Following the hearing, the record was left open until [redacted] so that Appellant's mother could submit an affidavit and the parties could file closing briefs.

ISSUE

Did the Department properly determine Appellant was not eligible for the Home Care Children program?

FINDINGS OF FACT

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

1. Appellant is a [redacted] who has been diagnosed with a number of medical conditions, including a mitochondrial disorder, intractable epilepsy/seizures, severe hypotonia, severe global developmental delays, microcephaly, cortical blindness/visual impairment, and dysphagia. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, pages 8, 48, 71, 79).[1]

2. Appellant previously lived in the state of [redacted] and, while living

[1] Appellant also noted that, [redacted] Appellant's "[future complications may include cardiac disease, liver disease, diabetes, and respiratory complications." (Respondent's Exhibit 1, page 80). However, it is undisputed that Appellant has not been diagnosed with any of those conditions at this time.

there, he received services such as physical therapy, occupational therapy, speech therapy and aquatic therapy through a program authorized pursuant to Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). (Appellant's Exhibit 3, ¶ 6; Respondent's Exhibit 1, page 73).

3. Appellant and his mother also received respite care while they were living in New Hampshire. When respite was used, Appellant would stay at the [redacted]. (Appellant's Exhibit 3, ¶ 12).

4. In [redacted] after Appellant and his mother moved to Michigan, Appellant's mother applied for the Home Care Children program on Appellant's behalf. (Respondent's Exhibit 1, page 7; Testimony of [redacted].

5. Appellant's application was reviewed by [redacted] Nurse Consultant for Children's Special Care Services. (Testimony of [redacted].[2]

6. As part of the review process in this case, [redacted] submitted Appellant's case for review of Supplemental Security Income (SSI) medical eligibility and it was determined that Appellant would be SSI eligible if institutionalized. (Respondent's Exhibit 1, pages 1-2, 27-28; Testimony of [redacted].

7. The review process also revealed the significant effects of Appellant's medical conditions. As summed up by [redacted] he has "significant developmental delays in all domains (cognition, fine and gross motor, self-help, speech and language). (Respondent's Exhibit 1, page 61). In many areas, Appellant is at the development level of a child less than a year old. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, page 80).

8. In particular, Appellant has difficulty with feedings, frequent gagging and swallowing difficulties. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, page 80). Therefore, he requires a trained person to feed him through a g-tube. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, page 79). Appellant also requires multiple medications that must be administered through a g-tube. (Appellant's Exhibit 1, page 1).

9. Appellant also cannot crawl and, while he uses a special stroller and

[2] On September 22, 2011, Richardson sent a letter to Appellant's mother requesting additional information. Specifically, Richardson sought information "that relates to what are the significant functional limitations your son experiences, and how those are being addressed" as well as "an evaluation or identification of care needs that relate to the substantial functional limitations experienced." (Respondent's Exhibit 1, page 77). The information subsequently received was also reviewed by Richardson prior to his decision being made.

walker, he cannot stand or move unassisted. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, pages 9, 49, 51, 73, 80). [redacted] further wrote that "[s]ince he cannot move by himself, he needs to be moved regularly to prevent pressure ulcers." (Appellant's Exhibit 1, page 1).

10. With respect to sitting, while it appears that Appellant was at one time able to sit unassisted, he lost that ability and still needs some support to sit and control his neck/head. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, pages 9, 51, 61, 80).

11. Appellant cannot speak or communicate. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, page 51).

12. Appellant also has approximately 30 daily seizures. (Appellant's Exhibit 1, page 1; (Respondent's Exhibit 1, page 80).

13. Due to his seizures and other medical conditions, Appellant goes to multiple medical appointments on a monthly basis. (Appellant's Exhibit 2, page 2; (Respondent's Exhibit 1, pages 2, 80).

14. Appellant also has to go to the hospital on occasion. His mother reports calling 911 twice and taking Appellant to the hospital four to five times in the years 2009-2010 because of seizures. (Appellant's Exhibit 3, ¶ 11). Appellant also went to the hospital for three days in [redacted] because of his seizures. (Appellant's Exhibit 2, page 1; Appellant's Exhibit 3, ¶ 11).

15. Outside of the home and school, Appellant attends weekly physical therapy, occupational therapy, and speech therapy. (Appellant's Exhibit 2, page 1; Respondent's Exhibit 1, pages 2, 74, 81, 110-115). Services through the school also include occupational therapy and speech services. (Respondent's Exhibit 1, page 80).

16. Inside of the home, Appellant's mother is his primary caregiver. (Appellant's Exhibit 3, ¶ 2). She has had no formal training, but she has been taught how to care for Appellant. (Appellant's Exhibit 3, ¶ 2).

17. In turn, Appellant's mother has also taught other caregivers how to care for Appellant. (Appellant's Exhibit 3, ¶ 4). Those other caregivers care for Appellant about 15 hours per week. One is a student studying special education and the other is a retired para-pro. (Appellant's Exhibit 3, ¶¶ 3, 5).

18. With respect to specific and special skills necessary to care for Appellant, any caregiver would have to be trained in seizure care and how to administer food and medications through a g-tube. (Respondent's Exhibit 1, pages 62, 81).

19. Appellant's seizures are fairly well-controlled at this time. (Respondent's Exhibit 1, pages 8, 74).

20. Similarly, the prognosis for improvement of feeding and swallowing skills through therapy is good. (Respondent's Exhibit 1, page 115).

21. On [redacted] the Department sent Appellant's mother written notice that the request for Home Care Children program services was denied. The reason given in the denial was that "[y]our son has been determined to not meet the criteria of: '(i) the individual requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility.' The basis for the decision is within Bridges Eligibility Manual (BEM) 170 of the Department for Human Services." (Petitioner's Exhibit 3, page 3).

22. On [redacted] the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on behalf of Appellant. In that request, Appellant argues that the Department erred in finding Appellant ineligible and that he clearly meets the level of care required for the program. (Petitioner's Exhibit 3, pages 1-2).

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 Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) added a provision to Title XIX of the Social Security Act which expanded Medicaid coverage to children with a medical institution level of care need but who were otherwise ineligible for Medicaid due to a higher family income. The program is also referred to as the Katie Beckett

program. *See* P.L. 97-248, Section 134. In essence, the Katie Beckett provision in TEFRA allowed states to waive the requirement for considering parental income in the process of determining Medicaid eligibility.

The implementing provision of the Code of Federal Regulations, as related to TEFRA individuals under age 19 who would be eligible for Medicaid if they were in a medical institution is, in pertinent part:

> (a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.
>
> (b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:
>
> (1) The child requires the level of care provided in a hospital, SNF, or ICF.
> (2) It is appropriate to provide that level of care outside such an institution.
> (3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.
>
> (c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home. [42 CFR 435.225.]

The State of Michigan operates a medical coverage program for children eligible under the TEFRA provision with approval from the Centers for Medicare and Medicaid Services (CMS). The program is titled Home Care Children and is housed within the Department of Community Health (MDCH) Children's Special Health Care Services Division (CSHCS). Because the State of Michigan opted to operate the Home Care Children program it must offer the program statewide, and must determine for each child requesting eligibility determination, whether he meets the three conditions of 42 CFR 435.225(b). Because the TEFRA provision includes eligibility for Medicaid benefits the Department is required to send a written notice of Home Care Children denial and the Appellant possessed a right to a Medicaid fair hearing. *See* 42 CFR 431.200 *et seq*.

The State of Michigan's policy is consistent with the Social Security Act, Code of Federal Regulations and State Plan. The State of Michigan Bridges Eligibility Manual (BEM) 170 lists the criteria for eligibility and delineates the division of eligibility determination responsibility between the Department of Community Health and the Department of Human Services:

> **DEPARTMENT POLICY**
>
> **MA Only**
>
> This is an SSI-related Group 1 MA category.
>
> MA is available to a child who requires institutional care but can be cared for at home for less cost.
>
> The child must be under age 18, unmarried and disabled. The income and assets of the child's parents are **not** considered when determining the child's eligibility.
>
> The Department of Community Health (DCH) and DHS share responsibility for determining eligibility for Home Care Children. All eligibility factors must be met in the calendar month being tested.
>
> **NONFINANCIAL ELIGIBILITY FACTORS**
>
> **DCH Responsibilities**
>
> DCH determines if medical eligibility exists. That is:
>
> - The child requires a level of care provided in a medical institution (i.e., hospital, skilled nursing facility or intermediate care facility); and
>
> - It is appropriate to provide such care for the child at home; and
>
> - The estimated MA cost of caring for the child at home does **not** exceed the estimated MA cost for the child's care in a medical institution.
>
> DCH also obtains necessary information to determine whether the child is disabled and forwards it to the DHS State Review Team (SRT). If the criterion in BEM 260 is met, disability will be certified on a DHS-49-A, Medical-

> Social Eligibility Certification, by the SRT. [BEM 170, page 3 of 3.]

In this case, Appellant's application for the Home Care Children program was denied after the Department found that he did not meet all of the requirements listed in BEM 170. Specifically, the Department found that Appellant does not require institutional care or a level of care provided in a medical institution.

Regarding the level of care provided in a medical institution and required by the Home Care Children program, [redacted] testified that there is no specific definition or criteria for that level of care in policy. However, [redacted] also testified that, based on his education and experience, he has identified factors to look for in determining whether someone requires an institutional level of care. In particular, [redacted] will look for medical conditions or needs that require frequent assessments and judgments by trained medical personnel. [redacted] further testified that he looks for care needs that require an institutional setting. Additionally, [redacted] will take into account where a child would be placed if his parent(s) became unavailable.

However, in discussing the specific types of facilities identified in BEM 170, [redacted] testimony appears to suggest a lesser standard of care than his general testimony. [redacted] did testify that a hospital and SNF involve medical assessments and judgments on a regular basis, but he also testified that no such assessments or judgments are required in an ICF and that an ICF only provides services such as bathing and feeding routinely.

Moreover, as noted by Appellant, [redacted] testimony is problematic because he testified that he did not consider Appellant's need for a SNF or an ICF because Appellant is too young for a SNF and no ICFs exist in the state of Michigan. However, the policy does not require that a person actually be sent to a SNF or ICF, only that he or she require a level of care provided in a medical institution, such as that provided in a hospital, skilled nursing facility or intermediate care facility.

Both Appellant and Respondent cite to statutes in an attempt to further define what the level of care are provided in an ICF is. For example, Appellant noted that MCL 333.20108(1) contains a definition of ICF:

> (1) "Intermediate care facility" means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or distinct part thereof, certified by the department to provide intermediate care or basic care that is less than skilled nursing care but more than room and board.

However, that definition is not instructive because, as noted by Respondent, all children require more than room and board and the definition in turn depends on what intermediate or basic care entails.

Respondent points to MCL 333.21715(1)(a) which states that a nursing home shall provide

> (a) A program of planned and continuing nursing care under the charge of a registered nurse in a skilled facility and a licensed practical nurse with a registered nurse consultant in an intermediate care facility. This subdivision shall expire [redacted]

However, that statue is also not instructive as it relates to nursing homes and only alludes to an ICF.

More helpful, in this Administrative Law Judge's view, are the federal regulations regarding an intermediate care facility for Individuals with Mental Retardation (ICF/MR). For a person to be eligible for ICF/MR level of care services he must meet the criteria for active treatment through an ICF/MR facility. Specifically 42 CFR 440.150 provides:

> § 440.150 Intermediate care facility (ICF/MR) services.
>
> (a) "ICF/MR services" means those items and services furnished in an intermediate care facility for the mentally retarded if the following conditions are met:
>
> (1) The facility fully meets the requirements for a State license to provide services that are above the level of room and board;
>
> (2) The primary purpose of the ICF/MR is to furnish health or rehabilitative services to persons with mental retardation or persons with related conditions;
>
> (3) The ICF/MR meets the standards specified in subpart I of part 483 of this chapter.
>
> **(4) The recipient with mental retardation for whom payment is requested is receiving active treatment, as specified in § 483.440 of this chapter.**
>
> (5) The ICF/MR has been certified to meet the requirements of subpart C of part 442 of this chapter, as evidenced by a valid agreement between the Medicaid agency and the facility for furnishing ICF/MR services and making payments for these services under the plan.
>
> (b) ICF/MR services may be furnished in a distinct part of a facility other than an ICF/MR if the distinct part--

> (1) Meets all requirements for an ICF/MR, as specified in subpart I of part 483 of this chapter;
>
> (2) Is clearly an identifiable living unit, such as an entire ward, wing, floor or building;
>
> (3) Consists of all beds and related services in the unit;
>
> (4) Houses all recipients for whom payment is being made for ICF/MR services; and
>
> (5) Is approved in writing by the survey agency. [emphasis added]

Active treatment is defined in 42 CFR 483.440:

> § 483.440 Condition of participation: Active treatment services.
>
> (a) Standard: Active treatment.
>
> (1) Each client must receive a c ontinuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health s ervices and related s ervices described in this subpart, that is directed toward--
>
> (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
>
> (ii) The prevention or deceleration of regression or loss of current optimal functional status.
>
> (2) Active treatment does not include ser vices to maintain generally independent clients w ho are able to function with little super vision or in the absence of a continuous active treatment program.
>
> (b) Standard: Admissions, transfers, and discharge.
>
> (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

> (2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.
>
> (3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

Given the above policy, testimony, statutes and regulations, this Administrative law Judge finds that the level of care provided in a medical institution is less expansive than argued by Appellant and is similar to the general standard articulated by [redacted]. While [redacted] testimony is somewhat contradictory and problematic, he properly focused on the services and skills necessarily offered in a medical institution. Such services would include medical assessments or judgments by trained medical personnel, skilled nursing and active treatment. Only if Appellant requires those sorts of services should he be found to require the level of care provided in a medical institution.

With respect to that standard of care, Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in finding that he does not require the level of care provided in a medical institution and in denying his application for the Home Care Children program. For the reasons discussed below, this Administrative Law Judge finds that Appellant failed to meet that burden of proof.

Here, as discussed above, Appellant is a [redacted] who has been diagnosed with a number of medical conditions, including a mitochondrial disorder, intractable epilepsy/seizures, severe hypotonia, severe global developmental delays, microcephaly, cortical blindness/visual impairment, and dysphagia. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, pages 8, 48, 71, 79).

Regarding Appellant's diagnoses, a question did arise regarding his mitochondrial disorder. In his notes and testimony, [redacted] characterized the condition as a "questionable mitochondrial disorder" and noted that the diagnosis was still being worked on. (Respondent's Exhibit 1, page 1; Testimony of [redacted]. However, to the extent that [redacted] even disputes the existence of the mitochondrial disorder, Appellant's doctors have repeatedly made clear that the existence of the disorder is not in doubt, just its exact nature. (Respondent's Exhibit 1, pages 9, 50, 59, 74, 80). It also appears that, at least for [redacted] there is no need for further research:

> With respect to the work-up of his underlying diagnosis, we do not feel further testing is necessary at this time given the extensive work-up already performed by his previous neurologist in conjunction with experts in Atlanta, Boston, and Indiana. [Respondent's Exhibit 1, page 74.]

Nevertheless, the effect of any error regard ing Appellant's mitochondrial disorder is negligible. While the exact nat ure of the disorder was not deter mined, its effects are identified and are not disputed by [redacted] As descri bed by [redacted] the current effects of the mitochondrial di sorder are "systemic. He experiences loss of motor control, muscle weakness, swallowing diffi culties, poor growth, seizures, visual problems, and global developm ental delays." (Respondent's Exhibit 1, page 80). Similarly, the treatment for the differ ent types of mitochondrial disor ders, *i.e.* medications, is the same (Testimony of [redacted]; Respondent's Exhibit 1, page 72) and the existence of that treatment not disputed by [redacted] Given the lack of dispute regarding the effects of the mi tochondrial disorder and its tr eatment, any questioning by [redacted] of the existence of the diagnosis of a mitochondrial disorder is insignificant.

This Administrative Law Judge also finds t hat fact that Appellant received services in New Hampshire and would be SSI eligible if institu tionalized in Michigan to be of minimal significance. There is no little ev idence or discussion in the record regarding the New Hampshire program or its requirements. Likewise, while SSI in Michigan is a different program with diffe rent standards than the Home Care Childr en program, Appellant does not discuss SSI beyond noting the eligibilit y determination or discus s why it demonstrates that he requires an institutional level of care.

Similarly, the opinions offered in support of Appellant's argument that he requires a level of care provided in a medical institution are also unper suasive. F or example, while [redacted] wrote and testified that it was her prof essional opinion that Ap pellant could not be placed safely in a regular daycare and, inst ead, needed the specialized care provided in an institutional setting, she failed to specifica lly explain in her letter to [redacted] or in her testimony why Appellant needed suc h care and what type of me dical institution he would need to be placed in. (Appellant's Exhi bit 1, page 1; Testimony of [redacted]). [redacted] Appellant's social wor ker also opined that "If [Appellant's] parent could not care for him, he wou ld ne ed to be in a fac ility that p rovides bot h persona l care an d aggressive therapies at the level of a rehabilitation facili ty with the goal of increasing his level of independent functioning. " (Appellant's Exhibit 2, page 1). However, as noted by [redacted] a rehabilitation f acility is no t a hospit al, SNF or ICF. (Respondent's Exhibit 1, page 3). Those therapies are also being provided in an outpatient setting.

The effects of Appellant's medical conditi ons are significant and, as summed up above, they include "signific ant developmental delays in all domains (cognition, fine and gross motor, self-help, speech and language). (R espondent's Exhibit 1, page 61). In many areas, Appellant is at the development lev el of a child less than [redacted] an d [redacted] cannot speak or communicate. (Appellant's Exhibit 1, page 1; Respondent's Exhibit 1, page 51). [redacted] further wrote that "[s]ince [redacted] cannot move by himself, [redacted] needs to be moved regularly to prevent pressure ulcers." (Appellant's Exhibit 1, page 1).

However, despite his s ignificant medical conditi ons and t heir effects, Appellant is not in acute medical cris is and his c are is gen erally managed through regular medica l appointments and var ious outpatient therapies. As dis cussed above, Appellant goes to

multiple medical appointments on a monthly basis. (Appellant's Exhibit 2, page 2; (Respondent's Exhibit 1, pages 2, 80). He also receives weekly physical therapy, occupational therapy, and speech therapy. (Appellant's Exhibit 2, page 1; Respondent's Exhibit 1, pages 2, 74, 81, 110-115). More over, the staff at the Speech and Language Clinic at [redacted] reported in [redacted] that the "[p]rognosis for improvement of feeding and swallowing skills is good based on clinical observations to date and provided that medical status remains stable." (Respondent's Exhibit 1, page 115).

Appellant has been taken to the hospital five or six times in the last three years, but only once since [redacted]. (Appellant's Exhibit 2, page 1; Appellant's Exhibit 3, ¶ 11). Given his general treatment, Appellant does not appear to require institutional care. This is especially true given that Appellant's infrequent hospital trips were due to his seizures (Appellant's Exhibit 2, page 1; Appellant's Exhibit 3, ¶ 11) and, as discussed below, his seizures are now well-controlled.

The existence of Appellant's seizures is not in dispute, but [redacted] did question whether they are intractable and he ultimately concluded that the seizures were well-controlled. In his notes and testimony, [redacted] noted a normalized EEG in [redacted] of [redacted] the lack of any documented need to change the treatment Appellant's seizures, and the discontinuation of Diastat. (Respondent's Exhibit 1, page 1; Testimony of [redacted].

However, as noted by Appellant, [redacted] appears to have focused on the one normal EEG Appellant had in the past three years and he ignored every other EEG, all of which were abnormal. (Respondent's Exhibit 1, pages 9, 19-20, 63). Appellant also noted that his doctors have repeatedly described his seizures as intractable and that, while the medication was adjusted and reordered, he is still on Diastat. (Respondent's Exhibit 1, pages 8, 23, 53). Appellant's mother's affidavit also states that, while a new medication (Dilantin) helps, [redacted] has concerns about its long-term effects on Appellant's liver. (Appellant's Exhibit 3, ¶ 11).

Appellant does not point to where or when [redacted] made the above statement. Moreover, Appellant ignores the statements of his doctors regarding how well his seizures are controlled. For example, [redacted] wrote in his [redacted] clinic note that, while Appellant has intractable epilepsy, "now the seizures are in better control, although he still has tremors and staring spells, some of that manifest as sudden mouth opening." (Respondent's Exhibit 1, page 8). Similarly, [redacted] wrote in [redacted] of [redacted] that "[redacted] seizures are fairly well-controlled at this time, and [redacted] mother is pleased with where [redacted] is clinically." (Respondent's Exhibit 1, page 74). Given those findings, [redacted] properly found that Appellant's seizures are fairly well-controlled.

The fact that Appellant's seizures are fairly well-controlled is particularly significant in light of the fact that training to react to seizure is one of the two areas where Appellant's caregivers must be trained. As discussed above, Appellant's mother is [redacted] primary caregiver and, while she has had no formal training, she has been taught how to care

for Appellant and has taught others how to care for Appellant. (Appellant's Exhibit 3, ¶¶ 2, 4). Regarding Appellant's general care, [redacted] wrote that "successful interventions require consistent structured programs, endless repetition, and patience. Caring for [redacted] demands extra insight, creativity, and resourcefulness. Mother realizes the high burden of care and necessity for community-based respite services." (Respondent's Exhibit 1, page 62). However, with respect to specific and special skills necessary to care for Appellant, [redacted] only found that "any caregiver would have to be trained in seizure care and hot to administer food and medications through a g-tube." (Respondent's Exhibit 1, page 81). [redacted] also noted that any caregiver would have to be trained in seizure care and how to administer food and medications via a g-tube. (Respondent's Exhibit 1, page 2).

It is undisputed that Appellant has significant medical issues. However, even Appellant's mother concedes that she and the paid caregivers can take care of Appellant without undergoing formal training. If Appellant's parent and caregivers can provide appropriate care despite the lack of formal training, then Appellant does not appear to require an institutional level of care.

Moreover, the undisputed fact that some training is required before a person would be qualified to care for Appellant does not mean that institutional care is required. Appellant's mother and the other caregivers can be trained to provide the appropriate amount of care and the only training they must undergo is with respect to seizures, where Appellant's seizures are fairly well-controlled, and a g-tube.

Appellant has a lot of needs, but he does not appear to require an institutional level of care given the assistance he receives in the home, who provides that assistance, and the training those caregivers require.

As discussed above, Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in finding him ineligible for the Home Care Children program. Based on the evidence in this case, this Administrative Law Judge finds that Appellant failed to meet that burden. Appellant requires significant help with activities of daily living in the home, but the only specific training that is required to care for Appellant is limited to learning how to use a g-tube and how to properly respond to seizures. Moreover, his seizures are well-controlled through medication and, as conceded by [redacted] most day cares have workers trained to respond to seizures. Similarly, he goes to therapy for assistance with eating and the prognosis for improvement is good. Appellant does receive services such as occupational therapy, physical therapy, and speech therapy through outpatient services, but he is not in a medical crisis and rarely has to go to the hospital. Overall, Appellant does not require an institutional level of care and the Department's decision should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that App ellant does not require an institutional level of care and denied his applic ation for the Home Care Children program.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9-6-2012

***** NOTICE *****

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