STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2012-78521 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]. Attorney [redacted] appeared on Appellant's behalf. [redacted], Appellant's [redacted] and co-guardian; [redacted] Appellant's [redacted] Appellant's [redacted] and co-guardian; and [redacted], a psychologist, testified as witnesses for Appellant. [redacted], Assistant Corporation Counsel, represented the Macomb County Community Mental Health Authority (CMH). [redacted], Clinical Director; [redacted] Supports Coordinator (SC); and [redacted] Adult Placement Coordinator, testified as witnesses for the CMH.

ISSUE

Did the CMH properly deny Appellant's request that Appellant remain at [redacted] Neurological Rehabilitation Center ("Lighthouse")?

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] year-old female who has been diagnosed with Attention-deficit/hyperactivity Disorder NOS, Disruptive Behavior Disorder NOS, Anxiety Disorder NOS, moderate mental retardation, and seizure disorder. (Respondent's Exhibit A, pages 19, 34).

2. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant has been receiving services through the CMH. Since [redacted], Appellant has been placed at different homes within Lighthouse. (Appellant's Exhibit 2, page 1; Respondent's Exhibit A, page 27).

4. At [redacted] Appellant receives psychological/psychiatric services, social work services, Community Living Supports (CLS), and 24 hour a day care and supervision. (Respondent's Exhibit A, page 28).

5. Behaviors monitored at [redacted] include "self injurious behavior, physical aggression, verbal aggression (swearing), biting others, BM smears and accidents, noncompliance, and inappropriate social boundaries." (Appellant's Exhibit 2, page 8).

6. With respect to [redacted] Appellant's Person Centered Plan (PCP) dated [redacted], stated as an outcome: "Someday, I hope I will be ready to leave the Lighthouse and live in the community." (Respondent's Exhibit A, page 47).

7. The PCP was set to expire on [redacted]. However, regarding Appellant leaving Lighthouse, the PCP also stated that, the supports coordinator would monitor Appellant's progress and, when it appeared Appellant was ready for a less restrictive placement and less restrictive services, would assist other CMH staff, Appellant, and Appellant's family with the move. (Respondent's Exhibit A, pages 46-47).

8. Around the time that PCP was developed, the CMH decided to terminate its contract with Lighthouse effective [redacted] and that its consumers at that home would need to be transitioned out of [redacted] before that date. (Uncontested testimony at hearing).

9. On [redacted], [redacted] met with Appellant's family, teacher and attorney to discuss the CMH's general policies regarding [redacted] and the progress for developing a home for Appellant specifically. (Respondent's Exhibit A, page 96).

10. In her notes regarding that meeting and testimony during the hearing, Hartway stated that there was no "Plan B" regarding the move, but that services would be adjusted as necessary. She also acknowledged in both her notes and testimony that the transition would likely be difficult. (Respondent's Exhibit A, page 96; Testimony of [redacted]

11. In a Psychological Services Quarterly Summary dated [redacted], Psychologist [redacted] wrote that "[Appellant] is currently seeing Dr. [redacted] for psychiatric consultations and medication services. [redacted] was initiated on [redacted]. This has proven to be an effective medication regime for her." (Respondent's Exhibit A, page 103).

12. [redacted] also wrote that "March was a difficult month for [Appellant] . . . However, her target behaviors have decreased since [redacted]. There was no physical aggression, self injurious behavior or personal control noted in [redacted]. There has been no physical aggression, self injurious behavior or personal control noted thus far during the month of June." (Respondent's Exhibit A, page 104).

13. [redacted] further wrote that "[Appellant] continues to be seen on a weekly basis for individual psychotherapy . . . She is cooperative and pleasant during her treatment sessions." (Respondent's Exhibit A, page 104).

14. In a PCP Progress Review dated [redacted], [redacted] also noted that Appellant has been progressing and that, given MDCH's position on consumers living in less restrictive settings, the parties needed to work together to plan for Appellant leaving Lighthouse. (Respondent's Exhibit A, page 60).

15. [redacted] further noted that Appellant's family was not in agreement with the plan and had stated that they believed the proposed move was based on financial reasons and nothing more. (Respondent's Exhibit A, pages 60, 74).

16. On [redacted], the CMH sent Appellant's guardian written notice regarding the revised PCP and Appellant's right to appeal. (Respondent's Exhibit A, pages 7-9).

17. On [redacted], Appellant, Appellant's family, and [redacted] met with [redacted] from Friends and Family, Inc. ("Friends and Family") regarding possible homes for Appellant. Both Appellant's and her family's concerns regarding staffing and the gentle teaching method used by Friends and Family were discussed. (Respondent's Exhibit A, page 97).

18. On [redacted], Appellant was assessed by the Macomb Oakland Regional Center, Inc. ("MORC") for possible placement in an alternative community residential living. (Appellant's Exhibit 2, pages 1-13).

19. As part of that assessment, [redacted] staff noted that [redacted] uses unspecified physical intervention techniques and that MORC has sought more information regarding those interventions. The assessment also stated that [redacted] would only use physical intervention as an emergency technique. (Appellant's Exhibit 2, page 3).

20. The [redacted] assessment also noted that, while [redacted] used restrictive measures in the form of contingent rewards, those restrictive measures "are not necessary and are not conducive to helping [Appellant] learn to self-regulate her response to stress, or to feel safe and engaged. This will note be promoted in her current plan." (Appellant's Exhibit 2, page 3).

21. However, a [redacted] Progress Note by [redacted] stated that Appellant's attorney had informed her that Appellant's guardians did not want to proceed with touring Friends and Family because they had filed a local appeal/dispute and a hearing request with MDCH. (Respondent's Exhibit A, page 98).

22. In a Psychological Services Quarterly Summary dated [redacted], [redacted] wrote that Appellant's medication regime was still effective (Respondent's Exhibit A, page 106) and that this "has been an excellent quarter for [Appellant]. There were only two incidents of physical aggression noted during this quarter. There were no usages of personal control during this past quarter. There were no incidents of self injurious behavior noted during the quarter. Non compliance and swearing remain her most frequently displayed target behaviors at this point in time." (Respondent's Exhibit A, page 107).

23. In a PCP Progress Review sated [redacted], [redacted] noted that Appellant was doing well with activities of daily living tasks and had a good quarter from a psychological perspective, with only two incidents of physical aggression noted and no usages of emergency personal control. (Respondent's Exhibit A, page 78).

24. [redacted] also wrote that Appellant was ready to transition out of [redacted] (Respondent's Exhibit A, page 78).

25. However, she also noted in the progress review that Appellant's guardians are "very happy with the services provided by the [redacted] and "vehemently opposed to [Appellant] leaving the [redacted] (Respondent's Exhibit A, page 78).

26. [redacted] further noted that Appellant's guardians had filed an appeal to dispute the plan. (Respondent's Exhibit A, page 92).

27. The CMH also sent Appellant's guardians written notice on [redacted] regarding the revised PCP and Appellant's right to appeal. (Respondent's Exhibit A, pages 10-12).

28. On [redacted], the Michigan Administrative Hearing System (MAHS) received a completed and signed Request for Hearing filed on behalf of Appellant. That request asserted that the CMH planned to end its contract with [redacted] without providing a safe, appropriate, and comparable placement for Appellant. (Respondent's Exhibit A, pages 14-15).

29. Appellant local appeal/dispute was heard on [redacted] and was subsequently denied on [redacted]. (Respondent's Exhibit A, pages 109-113).

30. While the CMH initially planned to terminate Appellant's placement at [redacted] on [redacted], it has extended Appellant's stay while the local dispute resolution and this appeal are pending.

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 also 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 Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

In this case, no one disputes that Appellant meets the criteria for Medicaid covered services. However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 C.F.R. § 440.230.

With respect to medical necessity, the Medicaid Provider Manual (MPM) states:

> **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.

- 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;

> experimental or investigational in nature; or

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

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

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis. [MPM, Mental Health and Substance Abuse Section, October 1, 2012, pages 12-14 (italics added by ALJ.]

One example of a Medicaid covered service that Appellant would receive regardless of where she is placed is Community Living Supports (CLS). Regarding CLS, the MPM provides:

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 (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 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.

> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child. [MPM, Mental Health and Substance Abuse Section, October 1, 2012, pages 113-114 (italics added by ALJ.]

Moreover, in addition to requiring medical necessity, the MPM also states that B3 supports and services, such as CLS, have other criteria and are meant to be provided in the least restrictive environment possible:

> **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 in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. 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. [MPM, Mental Health and Substance Abuse Section, October 1, 2012, pages 110-111 (italics added by ALJ.]

In this case, while Appellant seeks to remain at [redacted] specifically, she has no right to remain at any particular facility. However, the CMH plans on not only transitioning Appellant out of [redacted] but also moving her to a less restrictive setting. That issue is appealable and the question is therefore whether the restrictive level of services provided at [redacted] are medically necessary

With respect to those more restrictive services, the CMH argues that they are no longer medically necessary given Appellant's improvement and the stability she demonstrated in the months prior to the planned transition. Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying her request for continued placement at [redacted] or at a similar facility.

The improvement and stability Appellant has undergone since [redacted] is documented in the exhibits provided by Respondent. For example, as described above, the Psychological Services Quarterly Summary dated [redacted] described how Appellant's new medication had proven effective, Appellant was benefitting from cooperative weekly individual psychotherapy sessions, and how Appellant's target behaviors had decreased since March. (Respondent's Exhibit A, page 103-104). Subsequently, in the Psychological Services Quarterly Summary dated [redacted], [redacted] also wrote that Appellant's medication regime remained effective and it had been an excellent quarter for Appellant, with only two incidents of physical aggression noted, no usages of personal control, and no incidents of self injurious behavior noted. (Respondent's Exhibit A, page 107).

Appellant's representative and guardians do not dispute that Appellant has improved, but they also assert that the improvement Appellant has shown has taken years of services/treatment and has only happened because Appellant is familiar and comfortable at [redacted] Moreover, they and Appellant's psychologist assert that the improvement is not necessarily permanent as Appellant has undergone regression in the weeks between the filing of the appeal and the hearing.

However, even considering Appellant's familiarity with [redacted] her improvement is undeniable and she demonstrated significant stability over the course of months. Given that improvement and stability, the decision to transition her to less restrictive services should be affirmed.

As described above, the MPM states that, with regards to medical necessity, services should be provided in the least restrictive and most integrated setting possible, and that "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". (MPM, Mental Health and Substance Abuse Section [redacted], page 13). Similarly, the MPM states that B3 services in general should be provided in the "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." (MPM, Mental Health and Substance Abuse Section, [redacted], page 110).[1] Moreover, with respect to CLS specifically, the MPM further provides that "[s]taff 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[.]" (MPM, Mental Health and Substance Abuse Section, [redacted], page 114).

Here, the CMH staff has found that she is ready to transition to less restrictive services given her clear improvement and stability over the course of months. Similarly, Friends and Family appears to think she is ready and that the less restrictive home is appropriate for Appellant, which was not its position prior to Appellant's improvement. Moreover, the [redacted] assessment specifically states that the more restrictive services provided by [redacted] are unnecessary and are actually detrimental to Appellant's stability and improvement.

[1]With respect to B3 services, the MPM also states: "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." (MPM, Mental Health and Substance Abuse Section, [redacted], page 110). In this case, Appellant did not testify and, while her guardians are properly appealing the decision on her behalf, it is impossible to say what Appellant's goals are.

In light of those findings, the clear policy described in the MPM, and Appellant's improvement and stability over the course of the year, this Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the CMH erred in deciding to transition her out of [redacted] and into a less restrictive environment. Accordingly, the CMH's decision is sustained.

Nevertheless, while the decision to deny Appellant's request to remain at [redacted] is sustained, it is not clear what exact services will be provided in the future. [redacted] testified that the planning is still in process. Similarly, [redacted] testified during the hearing and wrote in progress notes that services will be adjusted as necessary and that there is not necessarily a "final" plan with respect to Appellant's needs and services. She also acknowledged in both her notes and testimony that the transition would likely be difficult. [redacted] further testified that the transition would not take place slowly, but would likely be difficult. She also testified that the plan would take the difficulty of transitioning into account.

Appellant's representative and family understandably have concerns about what those future services will be, but it also appears that they have delayed learning about various options that might be available. Moreover, it also appears that they have a fundamental misunderstanding of the gentle teaching approach used by a facility recommended by Respondent.

To the extent a decision regarding the implementation of services needs to made, that issue is not before this Administrative Law Judge. With respect to the issue that is before this Administrative Law Judge, *i.e.* the denial of the request to remain at [redacted] or a facility at the same restrictive level of [redacted] the CMH's decision is affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Appellant's request that she remain at [redacted]

IT IS THEREFORE ORDERED that:

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

/s/

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]
Docket No. 2012-78521 CMH
Decision and Order

cc: [redacted]

Date Mailed: January 2, 2013

***** 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.