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:

Docket No. 15-000700 CMH

[redacted], [redacted]

Appellant

_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. Appellant's father [redacted] appeared on behalf of the Appellant. [redacted], Appellant's CLS worker with [redacted], and [redacted] Appellant's mother testified on behalf of the Appellant.

[redacted] appeared on behalf of [redacted] Community Mental Health (CMH), representing the Department. [redacted], IDD Child and Family Specialist Case Manager, and [redacted], Chief Population Officer for Children and Families with [redacted] Community Mental Health appeared as witnesses for the Department.

ISSUE

Did CMH properly reduce Appellant's Community Living Supports (CLS) and Respite Care Services?

FINDINGS OF FACT

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

1. Appellant was an [redacted]-year-old Medicaid beneficiary (DOB [redacted] at the time of the hearing. Appellant has been diagnosed with Autism Spectrum Disorder that interferes with her academic, behavioral and social development. (Exhibit A, pp. 1, Appendix 1, pp.1-2, 5, Appendix 2 and testimony).

2. [redacted] Community Mental Health (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. Appellant was authorized to receive Medicaid covered services as a child with a developmental disability, including a mental health assessment, Family Training, Case Management, an annual clinical assessment, an evaluation of speech sound production, language, and expressive language, an occupational therapy evaluation, [redacted] hours per week of Community Living Supports (CLS) and [redacted] hours per month of Respite Care Services, and speech therapy, language therapy, and occupational therapy. Appellant attends school full-time at [redacted] School in a self-contained classroom for students with Autism Spectrum Disorder, and receives Occupational Therapy and Speech therapy through the school. (Exhibit A, pp. 2-3, 33-38; Exhibit 3 and testimony).

4. On [redacted] issued a notice that contained a reduction in the amount of CLS authorized for the Appellant from [redacted] hours per week to [redacted] hours per week and a reduction in the amount of Respite Care Services from [redacted] hours per month to [redacted] hours per month. The reason for the reduction was that the amount of CLS and Respite Care authorized was sufficient in amount, scope and duration to reasonably meet the Appellant's needs for CLS and Respite Care Services. (Exhibit A, pp. 2-3 and Appendices 2-3 and testimony).

5. On [redacted], MAHS received the Appellant's Request for Hearing. (Exhibit A, p. 9).

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 Community Mental Health (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. 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;
- that are experimental or investigational in nature; or
- that are 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. [*Medicaid Provider Manual*, *Mental Health/Substance Abuse*, October 1, 2014, pp. 12-14].

The *Medicaid Provider Manual*, *Mental Health/Substance Abuse*, January 1, 2015 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. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

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

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

Community Inclusion and Participation

The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club

meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).

Independence

"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity

Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. 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. [pp. 119-120, emphasis added].

* * *

17.3.B. COMMUNITY LIVING SUPPORTS

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

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

Coverage includes:

- Assisting, 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.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and

participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school. [pp. 122-123, emphasis added].

* * *

17.3.I. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid 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.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). [pp. 132-133].

In this case, it is undisputed that CLS and Respite Care services are medically necessary for the Appellant. On [redacted], CMH issued a notice that contained a reduction in the amount of Community Living Supports (CLS) authorized for the Appellant from [redacted] hours per week to [redacted] hours per week and a reduction in the amount of Respite Care services from [redacted] hours per month to [redacted] hours per month. The reason for the reduction was that the amount of CLS authorized was sufficient in amount, scope and duration to reasonably meet the Appellant's needs for CLS and Respite Care services. The prior authorization of [redacted] hours per week of CLS and [redacted] hours per month of Respite Care were maintained pending the Appellant's appeal of the reduction in services.

The witnesses for CMH provided credible evidence to show that they properly assessed the Appellant's need for Community Living Supports (CLS) and Respite Care Services. [redacted] Appellant's Case Manager stated the Appellant was authorized to receive the following Medicaid covered services through CMH; a mental health assessment, an evaluation of speech sound production, language, and expressive language, Targeted Case Management, [redacted] hours per week of CLS, [redacted] hours of Respite Care Services per month, speech and language therapy, occupational therapy. [redacted] stated the Appellant attends school full-time through the ISD five days per week and is out of the home from approximately [redacted]. to [redacted]. each day. Appellant is in a self-contained classroom for students with Autism Spectrum Disorder, and as part of her school day she receives Occupational Therapy and Speech therapy through the ISD school.

[redacted] stated he did a six month review of the Appellant's Individual Plan of Service (IPOS) in the Appellant's home with the Appellant's mother on [redacted] He stated that in their discussion Appellant's mother requested the CLS and Respite Care to continue as previously authorized. [redacted] stated as Case Manager he does not authorize services, this has to be done by his supervisor [redacted]. He stated he submitted the matter to [redacted] and she authorized [redacted] hours of CLS per week and [redacted] hours per month of Respite Care for the Appellant. [redacted] stated he prepared an Addendum to the Appellant's IPOS and incorporated the CLS and Respite Care hours authorized by [redacted] into the plan. He stated the plan was authorized by [redacted] on [redacted], and he sent the IPOS Addendum to the Appellant's parents on that date. The effective date of the IPOS Addendum was [redacted] [redacted] stated that an Adequate Action Notice was also sent out to the Appellant with an effective date of [redacted].

When questioned by the Appellant's father, [redacted] acknowledged that the goals for CLS in the IPOS Addendum were different than those in the [redacted] IPOS. The new goal was developed after the [redacted] month review with the Appellant's mother. [redacted] stated the discussions during the review centered on improving the Appellant's communication skills. Accordingly [redacted] identified the CLS goal in the Addendum as: "Chloe will improve communication skills by expressing her needs and preferences with words." The previous CLS goal was: [redacted] will improve safety and daily living skills in the community and at home."

[redacted] stated the addendum had a different focus. He acknowledged that the Appellant's main needs are communication and safety. [redacted] stated the Appellant has a problem with aggression due to her lack of communication skills. He also acknowledged that the Appellant engages in self-injurious behaviors such as poking, pinching, and slapping herself. She also directs this type of behavior at others. [redacted] stated the last annual clinical assessment for the Appellant before the IPOS Addendum in [redacted] was done in [redacted].

[redacted] stated it was her responsibility to authorize services for the Appellant. She stated she reviewed the Appellant's IPOS Addendum and made a decision in [redacted] of the services to be authorized for the Appellant. [redacted] stated she was aware of the services previously authorized, which included [redacted] hours per week of CLS and [redacted] hours per month of Respite Care. She stated she reduced the Appellant's CLS hours to [redacted] hours per week and Respite Care to [redacted] hours per month. [redacted] stated she reduced the Appellant's CLS hours because the Appellant had continued to improve over the past [redacted] years and the higher number of CLS hours were not medically necessary in light of the Appellant's improvement.

[redacted] stated she reviewed all of the Appellant's records and could not find support for the [redacted] hours of CLS requested for the Appellant. She pointed out that communication was the Appellant's major concern. [redacted] stated that the problem with the Appellant's behaviors and her aggression derived from her frustration with her inability to communicate and have others understand her. She stated that the Appellant needed CLS services to improve her ability to communicate and respond to verbal prompts. [redacted] stated that additional CLS services beyond what she authorized would not be valuable to the Appellant. [redacted] stated that in addition to the CLS workers, family members would be expected to work on prompting and helping to improve the Appellant's communication skills.

[redacted] stated she authorized [redacted] hours per month of Respite Care. She acknowledged that Respite Care is a B3 service and the policy quoted above from the Medicaid Provider Manual requires CMH to take into account their ability to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. She also acknowledged that policy states that parents of minor children with disabilities are expected to provide the same level of care they would provide to their children without disabilities. She stated that [redacted] hours per month of Respite Care was in excess of what parents would normally provide for children without disabilities, and that Respite Care is normally considered to be a [redacted] of hours in a day. [redacted] stated in her professional opinion the prior level of services were not medically necessary. Accordingly, [redacted] hours per week of CLS and [redacted] hours per month of respite services were sufficient in amount, scope, and duration to reasonably meet the goals in the Appellant's IPOS Addendum.

In response to the questions by the Appellant's father [redacted] stated the Appellant's assessments, both her annual clinical assessments and her two school assessments changed showing improvement. [redacted] stated when she initially

authorized the Appellant's services she approved the services at the previous level. She stated, however, that she is now looking at the Appellant's needs more closely and authorized the services based the information she had available to her. [redacted] also acknowledged there was dissatisfaction with the Appellant's speech and occupational therapy services provider and the speech and occupational therapy services are being transitioned to a new provider.

Appellant's main CLS Worker [redacted] testified on the Appellant's behalf. She said the Appellant can be very aggressive when she tries to communicate with you. [redacted] said it takes two people to keep Appellant safe at all times, and only on rare occasions is there only one adult present with the Appellant. She said the Appellant does have pica, and they need to make sure she isn't consuming anything that might be harmful to her. [redacted] said they always have to keep the Appellant at arms-length. She said the Appellant needs help with her daily hygiene skills. [redacted] said the Appellant hurts herself and others almost on a daily basis. She said the Appellant pushes, shoves, and hits other people. Appellant also engages in self abusive behaviors, hitting her head, pinching herself, and bruising herself. [redacted] said a parent is almost always in the home when a CLS worker is present. She said she and the Appellant's parents do respond consistently to the Appellant whenever she has communication issues. [redacted] said she works for [redacted], the agency that provides CLS and Respite Care services to the Appellant.

[redacted] testified that she was the Director of [redacted]. She testified that she does not provide direct care for the Appellant. She said they don't have a behavioral plan for the Appellant from CMH. [redacted] stated as a contract provider they are supposed to implement the behavioral plan given to them by CMH. She indicated that they wanted CMH to provide them with a behavioral plan because of the Appellant's aggression and her behaviors that cause a risk to other people.

The Appellant's mother testified the Appellant has constant needs. She said the Appellant needs constant supervision to keep her safe, and to keep others safe. Appellant's mother said the Appellant has pica and they must keep things out of her reach. She said the Appellant pokes herself, bites herself, bangs her head, and scratches and makes herself bleed. Appellant's mother said the Appellant also hits, kicks and pushes her [redacted] year old brother. She said the Appellant has so many sensory needs that they cannot let their guard down all day. The Appellant's mother said that she is concerned that without the additional CLS hours and without someone there to help her, she feels she will not be able to keep the Appellant safe. She thinks the Appellant will seriously injure herself or someone else without the additional CLS hours.

The Appellant bears the burden of proving by a preponderance of the evidence that additional units of CLS and Respite Care Services are medically necessary. The Appellant's witnesses were given the opportunity to prove why additional CLS units and Respite Care Services are necessary. The testimony of the Appellant's witnesses and the documentation presented on the Appellant's behalf did not establish medical necessity above and beyond the number of CLS hours and Respite Care Services

currently being authorized by CMH in accordance with the Code of Federal Regulations (CFR).

The CMH must authorize services in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when it authorized [redacted] hours per week of CLS and [redacted] hours of and Respite Care Services per month for the Appellant, in addition to the other Medicaid and community services the Appellant has been authorized to receive. Based upon the totality of the evidence, including the professional opinions of the CMH staff, [redacted] hours per week of CLS and [redacted] hours of Respite Care per month are sufficient to reasonably meet the Appellant's needs for CLS and Respite Care Services. The major concern identified by CMH was the need to work on the Appellant's ability to communicate and to be able to get others to understand her. The CLS hours authorized are in addition to the other Medicaid covered services the Appellant is authorized to receive, and the speech and occupational services she receives at school through the ISD. Finally, the parents who provide natural supports for the Appellant are also expected to assist with the development of the Appellant's communication skills, which should help to eliminate the Appellant's aggressive behaviors.

It also must be noted that the Respite Care Services are being authorized as B3 services. As stated above in the policy quoted from the Medicaid Provider Manual, 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. Respite Care is intended to be provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis. Also the CMH is required to take into consideration their documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. 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.

The Appellant has failed to prove by a preponderance of the evidence that additional units of CLS and Respite Care Services are medically necessary. The preponderance of the evidence demonstrates that CMH properly determined that [redacted] hours per week of CLS and [redacted] hours of Respite Care Services per month are sufficient to meet the Appellant's need for CLS and Respite Care Services, i.e., to reasonably meet the goals in the Appellant's person centered plan for CLS and Respite Care Services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that CMH properly authorized [redacted] hours per week of Community Living Supports (CLS) and [redacted] hours per month of Respite Care Services for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed [redacted]

WDB/db

cc: [redacted]

***** 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.