STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 15-009293 CMH

[redacted] [redacted] [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*. upon the request for hearing filed on Appellant's behalf.

After due notice, an in-person hearing commenced on [redacted] and was continued on [redacted]. [redacted] appeared on Appellant's behalf. [redacted], father; [redacted], mother; [redacted], brother, [redacted], CLS Worker; [redacted], Retired Case Manager; [redacted], RN, Rehab Clinical Nurse; and [redacted], Teacher, appeared as witnesses.

[redacted] represented Respondent, [redacted] (CMH or Department). [redacted], IDD Child and Family Supervisor; [redacted], Chief Population Officer; and [redacted], Case Manager, appeared as witnesses for Respondent.

ISSUE

Did Respondent properly deny Appellant's request for additional Community Living Supports (CLS) and Respite Care Services (RCS)?

FINDINGS OF FACT

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

1. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in its service area.

2. Appellant is an [redacted] year-old Medicaid beneficiary, born [redacted] who has been diagnosed with Autism Spectrum Disorder, Pica, and Pilaris Keratosis. Appellant is allergic to bee stings and Bactrim. Appellant has a history of frequent UTI's and ear infections. (Exhibits 1, 5; Testimony)

3. Appellant has been receiving services through CMH pursuant to the Habilitation Supports Waiver Program. (Exhibit 5; Testimony).

4. Appellant lives with her parents and younger brother in a single family home. Appellant's natural supports consist of her parents. (Exhibits 1, 5, D; Testimony)

5. Appellant needs help with communication, behavior and daily living skills. Appellant engages in self-injurious behavior, physical aggression towards others and herself and lacks adequate safety skills. Appellant needs supervision [redacted] hours per day, [redacted] days per week to keep herself and others safe from harm. (Exhibits 5, D; Testimony)

6. Appellant's self-injurious behaviors and aggression towards others are documented in the photographs in Exhibit A and the videos in Exhibit G.

7. Appellant attends school [redacted] through [redacted] from [redacted]. to [redacted] and is supported in a self-contained classroom for students with autism. Appellant also receives occupational therapy, school social work and speech therapy through the school district. The school district tracts Appellant's aggressive behavior. Appellant also attends a program at the school during the summer months. (Exhibit 1; Testimony)

8. Appellant receives the following Medicaid covered services through CMH as a child with a developmental disability: Community Living Supports (CLS), Mental Health Assessments, Speech and Language Evaluations, Respite Care Services (RCS), Annual Reviews and Assessments, and Supports Coordination. (Exhibits 5, E; Testimony)

9. Following an Individual Plan of Service (IPOS) meeting held on [redacted], Appellant was authorized to receive [redacted] CLS hours per week and [redacted] RCS per month. (Exhibits 5, E; Testimony).

10. On [redacted], CMH sent Appellant's parents an Adequate Action Notice outlining the services authorized in the [redacted] IPOS. (Exhibit 6; Testimony)

11. On [redacted] Appellant's parents requested that CMH authorize CLS and RCS as indicated in a draft IPOS dated [redacted]. Specifically, that draft IPOS authorized [redacted] CLS hours per week and [redacted] RCS hours per month. (Exhibit D; Testimony)

12. Appellant had previously received [redacted] CLS hours per week and [redacted] RCS hours per month, however, those services were reduced to [redacted] CLS hours per week and 1[redacted] RCS hours per month following an IPOS dated

[redacted]. Appellant's parents appealed this reduction, but the reduction was upheld following a hearing before Administrative Law Judge [redacted] in Docket No. 15-000700 CMH in [redacted] (Testimony)

13. On [redacted], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed on Appellant's behalf. (Exhibit H)

14. On [redacted], RN, completed a comprehensive assessment of Appellant. [redacted] recommended that Appellant minimally be authorized for [redacted] CLS hours per week and [redacted] RCS hours per month. (Exhibit C; Testimony)

15. On [redacted] Appellant's physician wrote a prescription for Appellant to receive [redacted] CLS hours per week and [redacted] RCS hours per month. (Exhibit H)

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.]

Moreover, 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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM) articulates Medicaid policy for Michigan. The MPM states with regard to medical necessity:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
>
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

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

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

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

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

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

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

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

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

    - that are experimental or investigational in nature; or

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

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

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
April 1, 2015, pp 12-14

With respect to the Habilitation Waiver, CLS and RCS, the MPM provides:

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 WAIVER SUPPORTS AND SERVICES

Community Living Supports (CLS)

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home nonvocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.
- Assistance, support and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;

- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);

- Leisure choice and participation in regular community activities;

- Attendance at medical appointments; and

- Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, 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 DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from 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 must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. 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.

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.

Respite Care

Respite care services are provided to a waiver eligible beneficiary 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. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "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 periods 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).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

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 full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.

- Licensed foster care home.

- Facility approved by the State that is not a private residence, such as:

    - Group home; or

    - Licensed respite care facility.

- Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDCH approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
April 1, 2015, pp 96-98; 111-112
Emphasis added

Here, Appellant was authorized to receive [redacted] CLS hours per week and [redacted] RCS hours per month following an IPOS dated [redacted] Appellant has appealed that authorization and requested [redacted] CLS hours per week and [redacted] RCS hours per month. As such, the issue is whether the CMH properly determined the amount of Appellant's CLS and RCS based on the information the CMH had at the time the decision was made in [redacted]. Given that Appellant's CLS and RCS were previously reduced in [redacted], and given that this reduction was upheld following an administrative hearing in [redacted], any actions taken before the [redacted] Decision and Order by ALJ [redacted] or after the Adequate Action Notice was issued on [redacted] are irrelevant to the determination as to whether the CMH's action taken on [redacted] was proper.

Appellant's Case Manager testified that he has worked for CMH since [redacted] and has been Appellant's Case Manager for about four years. Appellant's Case Manager indicated that in his capacity as case manager he has contact with Appellant and her family once per month, on average. Appellant's Case Manager testified that Appellant demonstrates aggressive behaviors towards herself and others and that these behaviors have always been a part of Appellant's condition. Appellant's Case Manager testified that there have been no significant changes in Appellant's behaviors in [redacted] Appellant's Case Manager indicated that Appellant attends school five days per week for full days and that she gets rides to school from her mother. Appellant's Case Manager testified that he authored the IPOS found in Exhibit 5 and that his supervisor authorizes services, not him. Appellant's Case Manager testified that Appellant sometimes wears a helmet at school for protection, but he could not recall if she ever

wore the helmet at home. Appellant's Case Manager indicated that Appellant is ambulatory and does not have a feeding tube. Appellant's Case Manager testified that the goals in Appellant's IPOS involved communication and safety and that the[redacted] CLS hours authorized were spread out over three separate goals. Appellant's Case Manager indicated that Appellant was also authorized for [redacted] RCS hours per month. Appellant's Case Manager testified that Appellant's parents signed the IPOS found in Exhibit 5 under duress.

On cross examination, Appellant's Case Manager testified that he has a Master's degree in Counseling Psychology, but is not a nurse or doctor. Appellant's Case Manager indicated that he recognized that Appellant requires a lot of care and requires supervision[redacted] hours per day, [redacted]days per week. Appellant's Case Manager explained his understanding of CLS. Appellant's Case Manager testified that staff are working with Appellant on her violent behaviors, as well as chores, eating, dressing and leisure activities. Appellant's Case Manager indicated that the decision to authorize services was made by his supervisor and that he has no decision making authority when it comes to the number of hours authorized. Appellant's Case Manager testified that in the draft IPOS found in Exhibit D, he did recommend that Appellant be authorized for [redacted] CLS hours per week and [redacted] RCS hours per month. Appellant's Case Manager indicated that the draft IPOS was then submitted to his supervisor, who made the actual authorizations, and he then entered those amounts into the final IPOS. Appellant's Case Manager testified that Appellant had been receiving [redacted] CLS hours per week and [redacted] respite hours per month for the entire time he had been her case worker, until services were reduced earlier in [redacted].

CMH's Chief Population Officer testified that she has held her current position for [redacted] years and that services for children with Intellectual and Developmental Disabilities (IDD) came under her supervision in [redacted] CMH's Chief Population Officer indicated that she was not directly involved with Appellant being approved for the HAB Waiver or with the authorization of services from the [redacted] IPOS, but was involved with the reduction of Appellant's services in [redacted] CMH's Chief Population Officer indicated that the Child and Family Supervisor took over in the spring of [redacted] and would have been the person who determined the services authorized in Appellant's [redacted] IPOS. CMH's Chief Population Officer testified that she believed the current amount of CLS and RCS authorized was appropriate and met medical necessity criteria. CMH's Chief Population Officer opined that the services authorized are appropriate because doing the same thing over and over again does not necessarily improve the outcome. CMH's Chief Population Officer testified that the fact that Appellant attends school also bears on her opinion, as Appellant does require some down time after school and should not be working on her goals from the time she gets home from school until the time she goes to bed.

On cross examination, CMH's Chief Population Officer testified that she holds a Master's in Social Work, obtained in [redacted], is licensed as a social worker in the State of Michigan, and has a certificate in Family Intervention. CMH's Chief Population Officer indicated that she did not dispute that Appellant needs [redacted] care. CMH's Chief

Population Officer explained her understanding of the HAB Waiver and B3 services. The remainder of CMH's Chief Population Officer's testimony on cross-examination related to the reduction of Appellant's services in [redacted] which is not at issue in the present case as that reduction was upheld following an administrative hearing held by Administrative Law Judge [redacted] in Docket Number 15-000700-CMH.

CMH's Child and Family Supervisor testified that she has been a supervisor at CMH since [redacted], was an outpatient therapist prior to that, and worked as a school counselor for [redacted] years working with children with developmental disabilities. CMH's Child and Family Supervisor indicated that she became involved in Appellant's case in [redacted] or [redacted] and officially became Appellant's Case Manager's supervisor on [redacted] CMH's Child and Family Supervisor testified that she authorized the services found in Appellant's [redacted] IPOS and felt that the services were medically necessary as authorized. CMH's Child and Family Supervisor indicated that she based her decision on discussions with Appellant's Case Manager and a review of Appellant's file. CMH's Child and Family Supervisor testified that she reviewed notes from Appellant's service providers, which showed that Appellant was doing well with prompts to wash her hands and brush her teeth. CMH's Child and Family Supervisor indicated that she felt [redacted] RCS hours per month were appropriate in Appellant's case and noted that RCS hours can be used flexibly as needed by Appellant's parents.

CMH's Child and Family Supervisor testified that CMH has been conducting an agency wide review of service authorizations as beneficiaries' plans come up for renewal because there had been an agency wide problem with authorizing more services than were medically necessary in the past. CMH's Child and Family Supervisor testified that the fact that Appellant attends school affected her decision. CMH's Child and Family Supervisor explained that Appellant attends school from [redacted] to [redacted] or [redacted] each day and then goes to bed at [redacted] each evening, leaving a period of five hours per day between the time school ends and Appellant goes to bed. CMH's Child and Family Supervisor testified that she did not feel that additional CLS hours on those days were medically necessary because Appellant also had informal supports available during that time.

On cross examination, CMH's Child and Family Supervisor testified that she is licensed as a counselor in the [redacted]. CMH's Child and Family Supervisor indicated that she never met Appellant or spent any time in the family's home. CMH's Child and Family Supervisor reviewed Exhibit D, the draft IPOS completed by Appellant's Case Manager, and indicated that she changed it into the final IPOS found in Exhibit 5. CMH's Child and Family Supervisor testified that she would have discussed the changes with Appellant's Case Manager, but that the Case Manager would make the actual changes in the IPOS. CMH's Child and Family Supervisor testified that she did not believe the level of services recommended by Appellant's Case Manager met medical necessity criteria. CMH's Child and Family Supervisor indicated that Appellant's risk for out of home placement did not increase in [redacted] and Appellant seemed to be showing some improvement.

Appellant's CLS Provider testified that she works part-time for [redacted] Appellant's CLS provider, and that prior to that she worked as a Case Manager for [redacted] years at CMH. Appellant's CLS Provider testified that she has a Bachelor's degree in sociology and is a licensed social worker in the [redacted]. Appellant's CLS Provider indicated that she was Appellant's Case Manager at CMH for approximately [redacted] years, ending in [redacted] Appellant's CLS Provider testified that she completed Appellant's IPOS's prior to leaving CMH in [redacted] and was the worker who determined Appellant's level of CLS and RCS prior to the reduction in [redacted] Appellant's CLS Provider testified that she believed the prior level of service, [redacted] CLS hours per week and 48 RCS per month, were medically necessary for Appellant. Appellant's CLS Provider indicated that she never discussed Appellant's case with CMH staff after the case was transferred. Appellant's CLS Provider indicated that she was surprised by the cuts to Appellant's services given that Appellant's needs are still the same. Appellant's CLS Provider reviewed the draft IPOS from [redacted] and opined that the amounts recommended were appropriate, but that the amounts authorized in the final IPOS were insufficient to meet Appellant's needs. Appellant's CLS Provider explained that Appellant has significant elopement issues and cannot go out into public with only one caregiver. Appellant's CLS Provider testified that she worked with CMH's Chief Population Officer for a short time, but could provide no explanation as to why she decided to reduce Appellant's services. Appellant's CLS Provider explained that the difference between the Children's Waiver and the HAB Waiver is a matter of funding. Appellant's CLS Provider testified that she believed that when Appellant was approved for the HAB Waiver, she was going to go back to the higher level or services, if not more services than before.

On cross examination, Appellant's CLS Provider testified that she works for a company that sells CLS services to CMH. Appellant's CLS Provider indicated that when she was at CMH she did not authorize services, her supervisor did. Appellant's CLS Provider testified that none of Appellant's skills improved while she was Appellant's Case Manager.

Appellant's Teacher testified that she has worked as a teacher at Appellant's school for the past five years and prior to that worked six years at a charter school. Appellant's Teacher indicated that she has a Master's degree in Autism. Appellant's Teacher indicated that Appellant is her student, has been in her class since the fall of [redacted], but she knew Appellant before that time. Appellant's Teacher indicated that Appellant attends school [redacted] through [redacted] from [redacted]. to [redacted] and that there is also a summer program. Appellant's Teacher testified that the school tracks Appellant's aggressive behaviors, which include her hitting her head against the wall, hitting herself with her fists, and hitting other students and teachers. Appellant's Teacher indicated that she has not been able to see a pattern in Appellant's aggressive behaviors. Appellant's Teacher indicated that Appellant has serious elopement issues and requires extensive prompting to do anything. Appellant's Teacher opined that Appellant would lose the skills she does have if she does not continue to work on those skills. Appellant's Teacher testified that it takes [redacted] to t[redacted] people to assist Appellant in using

the bathroom and that Appellant has frequent accidents while at school. Appellant's Teacher testified that she has not observed any improvements in Appellant's behaviors since [redacted]. Appellant's Teacher indicated that Appellant is large for her age, stronger and faster than other students her age, and is currently hormonal as well. Appellant's Teacher testified that Appellant always requires supervision. Appellant's Teacher testified that Appellant's classroom has six students and three staff.

On cross examination, Appellant's Teacher indicated that she has not seen an increase in Appellant's behaviors since the spring of 2015 and that she sees Appellant less in the summer.

A Registered Rehabilitation Clinical Nurse conducted a comprehensive assessment of Appellant in preparation for the hearing. (Exhibit C). The Registered Rehabilitation Clinical Nurse testified that she has a Bachelor's degree in Nursing, as well as graduate degrees and national certifications. The Registered Rehabilitation Clinical Nurse pointed to Exhibit B, which is her curriculum vitae. The Registered Rehabilitation Clinical Nurse indicated that she is currently in private practice and conducts medical case management. The Registered Rehabilitation Clinical Nurse testified that she conducted a thorough and full assessment of Appellant and her family to create her report. The Registered Rehabilitation Clinical Nurse discussed the stress Appellant puts on her family and indicated that there is no way the family could supervise and work with Appellant [redacted]. The Registered Rehabilitation Clinical Nurse testified that the Individualized Education Plan from the school supports her observations and what the family told her regarding Appellant. The Registered Rehabilitation Clinical Nurse testified that Appellant needs [redacted] care and monitoring and that care and monitoring needs to be one to one, and sometimes two to one. The Registered Rehabilitation Clinical Nurse testified that there appeared to be some semblance of order in the family home under the prior amount of CLS and RCS authorized, but she was not sure how the family was even able to survive with those higher amounts. The Registered Rehabilitation Clinical Nurse testified that from her review of Appellant's records, Appellant had shown no significant gains in the last [redacted] years. The Registered Rehabilitation Clinical Nurse testified that Appellant has not reached her functional limit and she could not understand the reduction in Appellant's services.

On cross examination, the Registered Rehabilitation Clinical Nurse indicated that she spend about two hours with the family and about eight to [redacted] hours reviewing Appellant's records in conducting her assessment. The Registered Rehabilitation Clinical Nurse testified that for skill building, endless repetition is the only way for Appellant to gain and maintain skills.

Appellant's mother testified that she attended [redacted], but did not finish the university program because Appellant was born and she had health issues from the start. Appellant's mother testified that at about [redacted] months old, Appellant began to lose skills she had developed. Appellant's mother indicated that Appellant was diagnosed with autism, pica, sensory modulation disorder and food allergies in

[redacted] Appellant's mother testified that she had never been told the prior services Appellant had received were not medically necessary and never heard such a thing until the first hearing date in [redacted] Appellant's mother testified that Appellant's goals in her IPOS have been consistent over the years.

Appellant's mother testified that she moved to the [redacted] area with Appellant after her diagnosis to attend early intervention ABA training for [redacted] months with a specialist. Appellant's mother indicated that Appellant first began receiving services through CMH in [redacted] Appellant's mother testified that Appellant's aggressive behaviors began around age [redacted] and that Appellant has seemed to have pica her whole life. Appellant's mother testified that Appellant needs more care now that she is older because she is bigger and her aggressive behaviors have increased. Appellant's mother testified that Appellant needs [redacted] on [redacted] and sometimes [redacted] on [redacted] care. Appellant's mother testified that if she is at home alone with Appellant, she often has to ask her young son to assist her. Appellant's mother testified that Appellant's father manages [redacted] bars in town and works long hours. Appellant's mother indicated that Appellant puts everything into her mouth, all day long, requiring constant supervision. Appellant's mother also described Appellant's self-injurious behaviors, which are also documented in the photographs in Exhibit A and the videos in Exhibit G.

Appellant's mother testified that she worked outside of the home prior to Appellant's diagnosis as a restaurant manager and waitress. Appellant's mother indicated that Appellant has many dietary restrictions, which adds significant time to meal preparations. Appellant's mother testified that her own mother also has Alzheimer's and she is her mother's guardian, which takes more of her time. Appellant's mother testified that she would like the prior level of services restored so that she can keep Appellant at home. Appellant's mother described a typical school day for Appellant. Appellant's mother indicated that no-one has ever told her that Appellant's current level of functioning is as good as she is going to get. Appellant's mother described how her sleep is interrupted every night because she has to keep an eye on Appellant through a video monitor. Appellant's mother described the care and training that Appellant is missing out on since her CLS hours have been reduced. Appellant's mother indicated that there are incredible safety concerns with Appellant as you only have to look away for one second for Appellant to get into a dangerous situation. Appellant's mother testified that the current amount of RCS is also not sufficient as the family is not able to do things together as they did in the past. Appellant's mother testified that CMH suggested that they apply for the HAB Waiver and that the family was told if they were approved for the HAB Waiver, they would receive more services than ever.

As indicated to the parties during the hearing, the reduction in Appellant's services in [redacted] was not at issue in this appeal, given that Appellant's parents previously appealed that reduction and the reduction was upheld by Administrative Law Judge [redacted] in Docket Number 15-000700-CMH. The parties were allowed to present evidence on the previous reduction for historical purposes only. The issue on appeal here arises out of the Adequate Action Notice mailed to Appellant's parents on

[redacted] regarding the authorization of services in Appellant's IPOS dated [redacted] In that IPOS, Appellant was authorized to receive [redacted] CLS hours per week and [redacted] RCS hours per month. In their appeal, Appellant's parents have asked that Appellant be authorized for [redacted] CLS hours per week and [redacted] RCS per month.

Based on the evidence presented, Appellant has proven, by a preponderance of the evidence that [redacted] CLS hours per week are insufficient to meet Appellant's needs. Appellant has failed to prove, by a preponderance of the evidence that [redacted] RCS hours per month are insufficient to meet Appellant's needs.

With regard to CLS, it is clear from the evidence that [redacted] CLS hours per week are insufficient to meet the goals in Appellant's IPOS. In support of this finding, one need look no further than the first goal in Appellant's IPOS: "Chloe will be safe at home and in the community." Even considering the significant time Appellant spends in school, [redacted] CLS hours per week are not enough to keep Appellant safe and give her an opportunity to work on the other objectives in her IPOS. No one disputed that Appellant needs [redacted] care in order to remain safe. While awake, Appellant requires one to one care and sometimes two to one care. While asleep, Appellant needs frequent interventions to ensure that she is safe. If Appellant gets home from school at approximately [redacted] each [redacted] and goes to bed at [redacted] that equals [redacted] hours per day, [redacted] days per week, or [redacted] hours per week where she needs care for her own safety and the safety of others. Appellant also, of course, requires care on the [redacted] when she is not in school. As such, even accounting for the informal supports provided by Appellant's family, [redacted] CLS hours per week are insufficient to keep Appellant safe and work on her goals.

CMH argued that 2[redacted] CLS hour per week were sufficient to meet the goals and objectives in Appellant's IPOS with [redacted] hours per week allocated to the goal of safety in the home and community, [redacted] hours allocated to the goal of increasing Appellant's verbal skills and prompts, and 5 CLS hours to help Appellant become more independent in the home. However, as indicated above, the undersigned does not believe that this allocation of CLS is sufficient to meet the goal of keeping Appellant safe in the home and community given Appellant's frequent aggressive behaviors towards herself and others, and her pica, which requires constant monitoring to ensure that Appellant does not put inappropriate or dangerous things in her mouth. It is clear that Appellant's needs are greater than many beneficiaries served by the CMH who may have more physical disabilities due to Appellant's aggressive, self-injurious behaviors. Furthermore, the undersigned did not find that the CMH did a very good job of supporting its assertion that [redacted] CLS hours per week were sufficient to meet Appellant's needs. CMH offered several justifications for the allocation of CLS that were simply not supported in the record, such as Appellant's behaviors and conditions had actually improved recently and that Appellant had somehow, at 1[redacted] years old, reached a plateau and could not be expected to improve in the future.

With that said, the undersigned does not have the authority to order the CMH to authorize a specific amount of CLS, but can only order that the CMH reassess Appellant considering most recent and up to date information available, including the [redacted] comprehensive assessment presented at the hearing (Exhibit C) and information from Appellant's school.

With regard to RCS, Appellant has failed to prove, by a preponderance of the evidence, that 1[redacted] RCS hours per month are insufficient to meet Appellant's needs. As indicated above, RCS hours are intended to be used 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." Based on the evidence presented, while not ideal, it appears that [redacted] RCS hours per month should be sufficient to give Appellant's parents short, intermittent breaks in the constant care that Appellant requires.

Appellant's parents should be commended on the enormous support that they provide to their daughter, which makes it possible for her to remain in the family home and out of a group home or institutional setting. Hopefully, Appellant's parents and CMH staff can work together to continue to provide the support needed to keep Appellant safe in her home and in the community.

At the close of Respondent's proofs, Appellant made a motion for a directed verdict and summary disposition on the grounds that the CMH's decision was not based on "clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary," as called for in Section 2.5.B, Determination Criteria, in the MPM. The motion was taken under advisement and is now denied as there was no evidence presented that there was any clinical information in Appellant's file that the CMH failed to consider at the time the decision was made. The [redacted] comprehensive assessment was not available to the CMH when they made the authorizations at issue in this matter on [redacted] Furthermore, the same section of the MPM also provides that decisions must be made by "appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience." Here, the Master's level social workers who made the decision in Appellant's case had sufficient clinical experience to make said decision.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly authorized [redacted] CLS hours per week, but properly authorized [redacted] RCS hours per month.

IT IS THEREFORE ORDERED that:

Respondent's decision is REVERSED with regard to CLS and AFFIRMED with regard to RCS.

Within [redacted] days of the issuance of this Decision and Order, the CMH shall takes steps to begin a reassessment of Appellant's CLS needs consistent with this decision and order and based on the most up to date information available.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of
Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

RJM/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.