[redacted]
[redacted], MI [redacted]

Date Mailed: October 28, 2020
MOAHR Docket No.: 20-002264
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing commenced on May 21, 2020. The May 21, 2020 hearing was adjourned due to all Exhibits not being received by the parties and was rescheduled for June 10, 2020. The June 10, 2020 hearing, as well as a rescheduled hearing on July 21, 2020 were both adjourned due to unavailability of an interpreter. A hearing was then held on August 26, 2020 and continued October 6, 2020.

Attorney Simon Zagata, Michigan Protection and Advocacy Services appeared on Petitioner's behalf. [redacted], Petitioner's Teacher and [redacted], Petitioner's father and guardian, appeared as witnesses for Petitioner.

[redacted] appeared as a translator for the August 26, 2020 hearing. [redacted] appeared as a translator for the October 6, 2020 hearing.

Stefanie Zin, Fair Hearing Officer, appeared and testified on behalf of Respondent, Community Mental Health Authority for Clinton, Eaton, and Ingham Counties. (CMH, Respondent or Department). Todd McGee, Supports Coordinator; Aaron Bakken, Residential Coordinator; Clorisa Adleman, Transitions Coordinator; and Drew Kersjes, Residential Supervisor, appeared as witnesses for Respondent.

EXHIBITS

Petitioner's Exhibits:

Exhibit A: Nursing Assessment, dated January 7, 2020

Exhibit B: Internal Appeal Request, dated January 30, 2020

Exhibit C: Comprehensive Functional Assessment, dated August 2, 2019

Exhibit D: Positive Support Plan, dated August 12, 2019

Exhibit E: Assessment, dated November 14, 2019

Exhibit F: Special Investigative Report, dated October 23, 2019

Exhibit G: Summary of Report of Investigative Findings, dated January 3, 2020

Exhibit H: Email from [redacted], dated November 7, 2019

Exhibit I: Email from [redacted], dated November 8, 2019

Exhibit J: Email from [redacted], possibly dated January 15, 2020

Exhibit K: Letter to [redacted], dated January 22, 2020

Exhibit L: Notice of Adverse Benefit Determination, dated February 11, 2020

Exhibit M: Notice of Local Appeal Decision, dated March 12, 2020

Respondent's Exhibits:

Exhibit A: Request for Administrative Hearing, dated April 10, 2020

Exhibit B: Notice of Local Appeal Decision, dated March 12, 2020

Exhibit C: Internal Appeal Request, dated February 12, 2020

Exhibit D: Letter to [redacted], dated February 11, 2020

Exhibit E: Letter to [redacted], dated January 28, 2020

Exhibit F: Adverse Benefit Determination Notice, dated January 28, 2020

Exhibit G: Email from [redacted]

Exhibit H: Activity Logs, dated December 2019 through January 2020

Exhibit I: Case Management Service Note, dated March 13, 2020

Exhibit J: Case Management Service Note, dated February 18, 2020

Exhibit K: Treatment Plan Annual/Initial, dated January 8, 2020

Exhibit L: Assessment, dated November 14, 2019

Exhibit M: Comprehensive Functional Assessment, dated August 2, 2019

Exhibit N: Positive Support Plan, dated August 12, 2019

ISSUE

Did the CMH properly authorize Petitioner's Personal Care and Community Living Supports (CLS) Services in a Licensed Residential Setting?

FINDINGS OF FACT

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

1. Petitioner is a [redacted]-year-old Medicaid beneficiary, born [redacted], receiving services through the CMH. (Resp Exhibit C, p 1; Testimony)

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

3. Petitioner is diagnosed with severe intellectual disability, blindness in both eyes, bilateral unspecified hearing loss, and epilepsy. Petitioner's father is her guardian. (Resp Exhibit M, p 4; Testimony)

4. Since September 2018, Petitioner has lived in [redacted] home in [redacted], Michigan, a specialized residential setting. The facility has two staff members and six residents. (Pet's Exhibit E, p 6; Testimony)

5. Petitioner does not speak but communicates with body language and vocalizations. Petitioner requires full assistance in all areas of personal care. Petitioner eats a pureed diet and is unable to feed herself. Petitioner requires assistance with dressing and wears diapers because she is not toilet trained. Petitioner can use the toilet if someone takes her to the bathroom. Petitioner is very mobile and loves to walk but needs assistance if in an unfamiliar environment. (Pet's Exhibit C, p 2; Testimony)

6. Petitioner engages in self-injurious behavior, such as striking her head against surfaces, when she is bored, adjusting to new staff, or not getting the attention that she needs. Petitioner can be redirected from self-injurious behavior. (Pet's Exhibit D, p 1; Testimony)

7. Petitioner is currently approved for 91.25 hours of community living supports (CLS) and 91.25 hours of personal care per month, for a total of 182.5 hours of care per month or approximately 42.6 hours of care per week. Petitioner sleeps for approximately 56 hours per week and attends school for 25 hours per week, leaving 77 hours per week that Petitioner is awake while at [redacted]. (Pet's Exhibits B, C; Testimony)

8. Beginning in the fall of 2019 and continuing into the winter of 2020, Petitioner requested 1:1 staffing for all her waking hours, or an increase in CLS and personal care to fill the gap between the 42.6 hours or care Petitioner currently receives and the 77 hours per week she is awake. (Pet's Exhibit H, I, J, K, L; Testimony)

9. Following a review, the CMH determined that Petitioner's request for increased CLS and personal care was not medically necessary. (Resp Exhibit F; Testimony)

10. On January 28, 2020, CMH sent Petitioner an Adverse Benefit Determination Notice informing Petitioner of the denial. (Resp Exhibit F; Testimony)

11. On February 12, 2020, Petitioner requested an Internal Appeal. (Resp Exhibit C; Testimony)

12. On March 12, 2020, following a Local Appeal, CMH notified Petitioner that it was upholding its original determination and denying Petitioner's request for increased CLS and personal care services. (Resp's Exhibit B; Testimony)

13. On April 7, 2020, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Resp's Exhibit A)

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 Health and Human Services (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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; and

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

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

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

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

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:

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

    - experimental or investigational in nature; or

    - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that

otherwise satisfies the standards for medically-necessary services; and/or

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

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

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 14-16

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);

- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

“Assisting” means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility

licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

An assessment of the beneficiary's need for personal care.

An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.

Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 78-79
Emphasis added.

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 non-vocational 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.
- Assisting, supporting 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 MDHHS 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 MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS 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 MDHHS 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 MDHHS 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.
>
> *Medicaid Provider Manual*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *January 1, 2020, pp 107-108*
> *Emphasis added.*

CMH's Supports Coordinator testified that he is a Licensed Professional Counselor, has worked at CMH for eight years and, prior to that worked with the developmentally disabled in a vocational setting. CMH's Supports Coordinator indicated that he has worked with Petitioner for approximately two years. CMH's Supports Coordinator testified that as a Supports Coordinator he monitors Petitioner programs, services and progress and ensures that her services are meeting her needs. CMH's Supports Coordinator testified that he believes the current level of supports and services are meeting Petitioner's medically necessary needs. CMH's Supports Coordinator indicated that he believes Petitioner is making good progress and that her behaviors have decreased over time spent at the AFC home. CMH's Supports Coordinator testified that Petitioner is authorized for community outings twice per week for at least 30 minutes.

CMH's Supports Coordinator testified that there are five other residents in the home, so six total counting Petitioner, and there are two staff persons at all times. CMH's Supports Coordinator testified that Petitioner both sits with other residents and actively gets up and walks around the home. CMH's Supports Coordinator noted that Petitioner also likes to go outside. CMH's Supports Coordinator testified that two of the other residents are able to move freely about the home and move objects. CMH's Supports Coordinator testified that Petitioner needs supervision when moving about the home but is very good at wall tracing. CMH's Supports Coordinator testified that Petitioner has exhibited aggression towards herself and staff but not towards other residents. CMH's Supports Coordinator testified that Petitioner does exhibit self-injurious behavior, mostly lying on the floor and hitting her head. CMH's Supports Coordinator indicated that staff try to catch Petitioner before she lies down. CMH's Supports Coordinator testified that

this behavior does not come on quickly and staff have one or two minutes to redirect Petitioner before she starts hitting her head.

CMH's Supports Coordinator testified that when Petitioner goes on community outings, she has at least one and sometimes two staff with her. CMH's Supports Coordinator noted that two staff usually accompany Petitioner to doctor's appointments, but one staff can handle if an outing is short and predictable. CMH's Supports Coordinator testified that when Petitioner goes out, there are still two staff in the home. CMH's Supports Coordinator indicated that Petitioner gets agitated when she has to wait so that is why two staff accompany her to doctor's appointments. CMH's Supports Coordinator testified that Petitioner is safe in the van with just one staff driving and that policy indicates if there is an issue the driver will pull over and deal with it. CMH's Supports Coordinator noted that this has not happened with Petitioner to his knowledge though.

CMH's Supports Coordinator testified that Petitioner needs assistance with personal hygiene, getting dressed and undressed, and eating and drinking. CMH's Supports Coordinator testified that Petitioner has been in the hospital in the past year and policy indicates that if there is an emergency staff call an ambulance. CMH's Supports Coordinator testified that he did not know how Petitioner got to the hospital the time she went in the past year. CMH's Supports Coordinator testified that there have been times when Petitioner's family has had to transfer Petitioner to doctor's appointments but that this arose because the family scheduled the appointments so quickly there was not time to find staff to cover the visit. CMH's Supports Coordinator testified though that he believes Petitioner has been provided adequate staff since being moved into the AFC home.

CMH's Residential Coordinator testified that he holds a Bachelor of Science degree in Community Development and has been with CMH for 14 years. CMH's Residential Coordinator testified that in his position he serves as a liaison with contracted providers to oversee the residential programs they operate through CMH. CMH's Residential Coordinator testified that he became involved in Petitioner's case in September 2018 when she moved to [redacted]. CMH's Residential Coordinator indicated that he worked to make sure that the transition was thought out and went smoothly. CMH's Residential Coordinator testified that he authored Respondent Exhibit G, which outlined the decrease in Petitioner's behavioral issues since she has been at [redacted]. CMH's Residential Coordinator testified that Petitioner did have significant behavioral issues when she first moved to the home, including an increase in self-injurious behavior and aggression. CMH's Residential Coordinator noted that these issues were related to medication changes and once the medications were corrected the behaviors decreased.

CMH's Residential Coordinator noted that at first Petitioner was averaging as high as 56 self-injurious behaviors and 59 aggressive behaviors per month, but now she is averaging about 3 of each such behaviors per month. CMH's Residential Coordinator testified that Petitioner has a safe and healthy relationship with staff at the home and is able to navigate the day without frustration. CMH's Residential Coordinator noted that

Petitioner is doing well despite changes to the school structure due to COVID-19. CMH's Residential Coordinator testified that he believes Petitioner's current levels of supports and services meet Petitioner's medically necessary needs. CMH's Residential Coordinator testified that he is aware that there was some relationship building time at the home with Petitioner and that the home manager sought guidance from CMH to meet Petitioner's specific needs. CMH's Residential Coordinator indicated that the home manager then trained staff to meet Petitioner's unique needs.

CMH's Residential Coordinator testified that staff have been trained to make Petitioner feel comfortable and safe in the home, to be more patient, thoughtful, and mindful when dealing with Petitioner, and trying not to put too many additional demands on Petitioner. CMH's Residential Coordinator testified that these changes began with having meetings between the staffing provider (Hope Network), Petitioner's family, and the CMH. CMH's Residential Coordinator indicated that needs and strategies were identified, and the parents asked that the home be open to hearing their input. CMH's Residential Coordinator testified that CMH focuses on a "culture of gentleness" approach, which identifies and respects each resident's individual needs.

CMH's Residential Coordinator noted that Petitioner does not communicate with traditional sign language but that is not unusual for someone with her conditions. CMH's Residential Coordinator testified that in addition to the changes in Petitioner's medications, other changes have led to a decrease in Petitioner's behaviors, such as time spent in relationships and getting Petitioner out in the community more to enjoy things. CMH's Residential Coordinator testified that he was familiar with the fact that boredom and wanting individual attention led to Petitioner acting out in the past but that things have changed dramatically in the home since then. CMH's Residential Coordinator noted that he did indicate in an email that 1:1 staffing for Petitioner had been approved but that decision was later determined to be not medically necessary by his supervisor.

CMH's Transitions Coordinator testified that she has multiple degrees in social work, is a Licensed Masters Level Social Worker, and has been with CMH since 2013. CMH's Transitions Coordinator testified that in her job she is the coordinator for the case management department and is responsible for the department's administrative functions as well as clinical consultations with case managers, including Petitioner's Supports Coordinator. CMH's Transitions Coordinator testified that she provides clinical consultation with Petitioner's Supports Coordinator one to four times monthly, or more if needed. CMH's Transitions Coordinator testified that, based on the information she has seen, she believes the current level of supports and services are adequate to meet Petitioner's medically necessary needs.

CMH's Transitions Coordinator testified that in coming to the above conclusion, she considered information shared with her during clinical consultations, a review of all records in the medical record, all of the exhibits in this case, plus anything shared in multi-disciplinary meetings she attended. CMH's Transitions Coordinator testified that she was aware that earlier documentation indicated that lack of individual attention was

a trigger for Petitioner's self-injurious behavior but that document is over a year old and they have seen significant improvement with Petitioner since that time. CMH's Transitions Coordinator noted that as other witnesses have indicated, time in the home, getting to know the staff, and changes in medication would all contribute to the decline in Petitioner's behaviors. CMH's Transitions Coordinator indicated that Petitioner is seen at least quarterly by a psychiatrist for mediation management. CMH's Transitions Coordinator testified that she has discussed with Petitioner's Supports Coordinator how staff were treating Petitioner in the home. CMH's Transitions Coordinator noted that she recently discussed with Petitioner's Supports Coordinator a meeting regarding increased screening for deaf and blindness and what equipment Disability Network might be able to provide Petitioner. CMH's Transitions Coordinator testified that occupational therapy, speech therapy, and psychological services have also been coordinated with [redacted]. CMH's Transitions Coordinator testified that while she has not had any recent direct interaction with Petitioner, she used to be Petitioner's Case Manager many years ago, before she moved to [redacted].

CMH's Residential Supervisor testified that he is a Limited License Social Worker and has nearly 11 years of experience in the field. CMH's Residential Supervisor testified that in addition to his role as a Residential Supervisor he is also certified as a trainer from group homes. CMH's Residential Supervisor testified that he oversees all the directly operated and contracted residential services available through CMH, including the home where Petitioner lives. CMH's Residential Supervisor noted that Hope Network owns the contract at [redacted] where Petitioner lives, and he oversees that contract. CMH's Residential Supervisor testified that he believes Petitioner's currently authorized services are meeting Petitioner's medically necessary needs.

CMH's Residential Supervisor testified that [redacted] is a licensed AFC home that includes both Personal Care and CLS care codes and Hope Network is contracted to provide these services at the home. CMH's Residential Supervisor testified that Hope Network licenses the home through state licensing requirements and has a licensed designee. CMH's Residential Supervisor noted that the designee identifies the staffing needs of residents in the home and it is the designee's responsibility to have enough flexibility in staffing to meet the needs of residents, if given enough notice of appointments.

CMH's Residential Supervisor testified on November 17, 2019, he met with Hope Network and CMH's Residential Coordinator to discuss that flexibility so that the home could meet Petitioner's needs, as well as the needs of others in the home. CMH's Residential Supervisor testified that the result of that meeting was that an adjusted staffing pattern was created so that Petitioner's needs in the home and in the community could be better met. CMH's Residential Supervisor testified that as demonstrated from the data since that time, he believes the home has made the necessary adjustments to meet Petitioner's needs. CMH's Residential Supervisor noted that the "culture of gentleness" training he conducts encourages staff to look at the home as a place to decrease demands on Petitioner. CMH's Residential Supervisor

testified that he understands that school is a place where increased demands are placed on Petitioner so they believe that the home should be a place where demands are decreased for Petitioner's overall health.

CMH's Residential Supervisor testified that he is not a licensed psychologist or a physician. CMH's Residential Supervisor indicated that one of his roles is to review contracts with service providers but that he is also a certified trainer on individual care. CMH's Residential Supervisor testified that staff at Petitioner's home may have attended one of his trainings, but he could not say for sure. CMH's Residential Supervisor testified that while he is familiar with Petitioner's case and was part of a meeting between CMH and Michigan Protection and Advocacy Services, CMH's Residential Coordinator is more familiar with Petitioner's case and he supervises the Coordinator. CMH's Residential Supervisor testified that he has never visited Petitioner's home but has met her in the CMH offices.

CMH's Residential Supervisor testified that he believes the adjustment that was made to staffing was that the home manager's schedule was changed to ensure that she was in the home when Petitioner returned from school. CMH's Residential Supervisor testified that he agrees that licensing rules require staffing to be based on the needs of the residents and that Personal Care and CLS can be used in conjunction with the care provided in licensed settings. CMH's Residential Supervisor testified that he believes that Petitioner is not authorized for any specific number of Personal Care and CLS services but rather a range of services based on her needs and the needs of other individuals in the home. CMH's Residential Supervisor testified that the range depends on Petitioner's day to day needs. CMH's Residential Supervisor indicated that staffing adjustments do not necessarily mean another staff person is brought into the home; it may just mean that staff adjust from doing one thing, such as laundry, to another, such as directly caring for Petitioner.

CMH's Residential Supervisor testified that he was not aware of how many staff were in Petitioner's home but his opinion that Petitioner's needs was being met was based on the data coming from the home. CMH's Residential Supervisor noted that the home manager trains staff to deal with Petitioner and she is doing a good job. CMH's Residential Supervisor indicated that all providers have to adhere to training requirements and, as part of that training, they talk about all behavior being communication and the need to adjust in the moment to meet an individual's needs. CMH's Residential Supervisor testified that the more staff is able to get to know a person the faster they are able to adjust to meet that person's needs. CMH's Residential Supervisor testified that CMH relies on its contractor, Hope Network, to adjust care as needed in the home but it is a collaborative process between all parties. CMH's Residential Supervisor testified that CMH does not wait until there is a problem before making adjustments and that the Residential Coordinator is closely involved at all times. CMH's Residential Supervisor noted that the Residential Coordinator worked with Petitioner's Case Managers when she transitioned from one to the other so that there was no disruption in service and relationships could be built in the home.

Petitioner's Teacher testified that he has been Petitioner's special education teacher for the past two years, until the pandemic hit. Petitioner's Teacher noted that he is beginning his 20th year as a special education teacher and his 22nd year as a teacher overall. Petitioner's Teacher testified that from the moment Petitioner arrives at school until the time she leaves she has a one on one paraprofessional with her in the classroom. Petitioner's Teacher indicated that Petitioner participates in activities, uses the adaptive gym, sees therapists, and works on daily living and personal care activities such as toileting and dressing. Petitioner's Teacher testified that the principal at the school decided that Petitioner needed one to one support. Petitioner's Teacher noted that because Petitioner is both blind and deaf, but a high ambulator, there is a high chance of her being injured. Petitioner's Teacher testified that while Petitioner does not stumble often, she does go down to her bottom on her own. Petitioner's Teacher indicated that if Petitioner goes down to the floor and hits her head it can be pretty instantaneous and the paraprofessional tries to get a pillow to place between Petitioner's head and the floor while trying to redirect Petitioner. Petitioner's Teacher testified that the school only documents Petitioner engaging in self-injurious behavior if she suffers an injury, such as a bump on her head. Petitioner's Teacher noted that if Petitioner is seated near any hard surface, she will try to bang her elbow or head on the surface, even if she has a one to one paraprofessional. Petitioner's Teacher testified that it is not usually difficult for staff to redirect Petitioner when she engages in self-injurious behavior as Petitioner will get right back up and keep ambulating.

Petitioner's Teacher testified that Petitioner's unique impairments are that she is blind and deaf but very mobile and walks constantly so someone needs to be with her at all times as she cannot see to avoid danger or to avoid things. Petitioner's Teacher indicated that Petitioner is the first student he has every had with those unique impairments. Petitioner's Teacher indicated that Petitioner's last day at the school was March 17, 2020 due to the COVID-19 pandemic. Petitioner's Teacher testified that he could not recall the last documented self-injurious behavior for Petitioner at the school but did recall an incident from the prior school year where Petitioner hit her head so hard she had to go to the hospital. Petitioner's Teacher testified that the only method they use to keep Petitioner away from hard surfaces is always to have one staff person with her. Petitioner's Teacher indicated that if they leave Petitioner alone in a chair, she will slide to the floor and hit her head. Petitioner's Teacher indicated that Petitioner will also fall asleep if left alone and she will not wear a helmet. Petitioner's Teacher testified that they only document successful self-injurious behavior with Petitioner because if they documented attempts, it would be multiple times per day.

Hope Network's Program Manager testified that her role is to run the day to day operations at [redacted]. Hope Network's Program Manager indicated that she makes the schedule, makes sure everyone's needs are being met, and works the floor herself to ensure those needs are met. Hope Network's Program Manager testified that she works the floor herself to give other staff a break, or if staff calls in, or if residents in the home have appointments and staff have to go with them.

Hope Network's Program Manager testified that on a typical day, Petitioner would wake between 4:00 and 6:00 a.m., be taken to the bathroom for her personal care needs and a shower, then fed breakfast and given her morning medications. Hope Network's Program Manager testified that two days per week Petitioner goes to school, leaving at 7:05 a.m. and returning at 3:45 p.m. Hope Network's Program Manager testified that when Petitioner returns to school, she is taken to use the bathroom and then given a snack. Hope Network's Program Manager testified that depending on the day, Petitioner would then either walk around the house or lay down or sit at the table. Hope Network's Program Manager testified that on non-school days, Petitioner normally takes a short morning nap and has a snack between 9:00 a.m. and 11:00 a.m., with lunch around 12:30 p.m. Hope Network's Program Manager testified that Petitioner is taken to the bathroom about every hour and a half and takes a nap for a couple of hours after lunch. Hope Network's Program Manager testified that they make sure Petitioner is awake by 4:00 p.m. to take her medications then dinner is around 5:30 p.m. Hope Network's Program Manager testified that Petitioner then stays up for a few hours, has her medications at 9:00 p.m., is showered and in bed by 10:00 to 11:00 p.m.

Hope Network's Program Manager testified that staff assist Petitioner with all her ADL's. Hope Network's Program Manager indicated that there are currently seven staff in the home, with at least two on staff at all time and three staff for the first shift. Hope Network's Program Manager testified that the adjustments to the staffing schedule mentioned by CMH were that her schedule was adjusted to make sure she was in the home Monday through Friday until at least 5:00 p.m. Hope Network's Program Manager noted that she is also on call 24/7. Hope Network's Program Manager testified that this is different than before Petitioner moved to the home as she used to work more of a 7:00 a.m. to 3:00 p.m. shift. Hope Network's Program Manager noted that other than that change the only other adjustments are those made on a daily basis if someone has an appointment.

Hope Network's Program Manager testified that trips into the community are part of Petitioner's service plan and that she or staff take Petitioner on those outings. Hope Network's Program Manager noted that even when Petitioner is taken on community outings, there are still at least two staff in the home. Hope Network's Program Manager testified that Petitioner does engage in self-injurious behaviors, such as dropping to the floor and banging her head. Hope Network's Program Manager testified that Petitioner will also sometimes grab stuff or lash out at staff. Hope Network's Program Manager testified that the home tracks successful self-injurious or aggressive behaviors, not attempts at such behavior. Hope Network's Program Manager testified that Petitioner's self-injurious and aggressive behaviors have decreased in the past year. Hope Network's Program Manager attributed the decrease to training as well as learning about Petitioner and her needs and wants. Hope Network's Program Manager testified that she and staff participate in training at both Hope Network and CMH, including "culture of gentleness" training. Hope Network's Program Manager testified that she works with new staff herself to train them as she did a lot of personal care for Petitioner when Petitioner first moved in. Hope Network's Program Manager indicated that her

familiarity with Petitioner has helped to decrease Petitioner's self-injurious and aggressive behaviors.

Hope Network's Program Manager testified that more personal interaction could decrease Petitioner's behaviors on some days but sometimes Petitioner does not want others in her personal space. Hope Network's Program Manager testified that Petitioner is a fairly active person and likes to walk, sit in her chair, and spin on her bottom, and go outside and sit in the grass. Hope Network's Program Manager testified that staff need to be with Petitioner when she is outside, and staff need to watch Petitioner when she is walking around the home. Hope Network's Program Manager testified that if Petitioner is engaging in self-injurious or aggressive behaviors, staff will redirect her, move her away from something, or she could be hungry or need to use the bathroom.

Hope Network's Program Manager testified that there are others in the home with complex needs. Hope Network's Program Manager testified that she and staff track Petitioner's self-injurious and aggressive behaviors and then that data is shared with the psychologist. Hope Network's Program Manager testified that the CMH trainings have been helpful in learning to deal with Petitioner. Hope Network's Program Manager testified that she and staff provide support to residents so that behaviors do not occur. Hope Network's Program Manager testified that she agrees with the proposition that all behavior is a form of communication. Hope Network's Program Manager testified that she also agrees that between staffing ratio and the layout of the home, Petitioner is in staff sight at all times, even when she is in her room.

Petitioner's Guardian testified that Petitioner lived with he and her mother for 23 years before moving to [redacted]. Petitioner's Guardian indicated that Petitioner needs 100% help with all daily living tasks. Petitioner's Guardian testified that Petitioner has had to go to the doctor or the hospital due to injury in the past year on two occasions – once due to a head injury and once with pneumonia. Petitioner's Guardian testified that the head injury occurred at [redacted] and staff were apparently not around. Petitioner's Guardian indicated that when Petitioner needs something, she bangs her head. Petitioner's Guardian indicated that Petitioner has also pulled her own hair out when she is agitated. Petitioner's Guardian testified that he does not believe there are enough staff in the home to take care of Petitioner. Petitioner's Guardian indicated that Petitioner had very few injuries when living with them for 23 years but has had numerous incidents since moving to the home. Petitioner's Guardian testified that on two occasions, the home called him to take Petitioner to the doctor because they did not have staff to take her.

Petitioner's Guardian testified that Petitioner was present at a meeting with CMH in January 2020 and was trying to hurt herself during the meeting, even though staff was present with her. Petitioner's Guardian indicated that Petitioner was never left unsupervised when she lived with him. Petitioner's Guardian testified that when Petitioner lived at home, he also had help from CMH, at a rate of about seven hours per

day. Petitioner's Guardian noted that Petitioner was attended school during that time as well.

Petitioner's Guardian indicated that when Petitioner was injured in the AFC home and he had to take her to the hospital the worker begged him not to call the police. Petitioner's Guardian did say that he reported the incident to CMH. Petitioner's Guardian testified that the AFC home has called him numerous times to take Petitioner to doctor appointments because they did not have sufficient staff to take her. Petitioner's Guardian testified that in the 25 months Petitioner has lived at the AFC home, before COVID, they visited her over 200 times. Petitioner's Guardian testified that they provide all of Petitioner's food and have never requested money for that or the mileage driving back and forth. Petitioner's Guardian testified that they take food to Petitioner because she was used to only her mother's food. Petitioner's Guardian testified that they would be happy to take Petitioner back into the family home and she would not hurt herself there. Petitioner's Guardian testified that he and Petitioner's mother are responsible parents and what is done for Petitioner at the AFC home is not enough. Petitioner's Guardian testified that he is not sure how long it will take for Petitioner to return to being the person she was before.

Petitioner bears the burden of proving by a preponderance of the evidence that increased Personal Care and Community Living Supports are medically necessary. CMH provided sufficient evidence that it adhered to federal regulations and state policy when authorizing Personal Care and Community Living Supports at the current level. Petitioner failed to prove by a preponderance of the evidence that the additional services were medically necessary.

As indicated above, based on the evidence presented, Petitioner is making good progress and her aggressive and self-injurious behaviors have decreased over time spent at the AFC home. Petitioner was averaging as high as 56 self-injurious behaviors and 59 aggressive behaviors per month, but now she is averaging about 3 of each such behaviors per month. (See Respondent's Exhibit G). And while Petitioner did have significant behavioral issues when she first moved to the home, including an increase in self-injurious behavior and aggression, some of these issues were related to medication changes and others were simply related to being in an unfamiliar environment. Petitioner's medications were adjusted, there was some relationship building with staff, and, with guidance from CMH, the home manager's schedule was adjusted to better meet Petitioner's needs. Petitioner now has a safe and healthy relationship with staff at the home and can navigate the day without frustration. Staff have been trained to make Petitioner feel comfortable and safe in the home, to be more patient, thoughtful, and mindful when dealing with Petitioner, and trying not to put too many additional demands on Petitioner.

And, while there have been times when Petitioner's family has had to transfer Petitioner to doctor's appointments, this arose because the family scheduled the appointments so quickly there was not time to find staff to cover the visit. Also, while the school has decided that Petitioner always needs a one to one paraprofessional, that does not

necessarily mean that Petitioner needs one to one care in the home. As indicated, school is a place where increased demands are placed on Petitioner so it makes sense that she may be somewhat stressed and need one to one care. Home, on the other hand, is a place where demands are decreased for Petitioner's overall health, so she does not need one to one care in the home. However, Petitioner is supervised 24/7 and is always in the sightline of staff. CMH is also looking into what equipment Disability Network might be able to provide Petitioner to help her in the home. As noted, while Petitioner needs supervision when moving about the home, she is very good at wall tracing. Petitioner is also seen at least quarterly by a psychiatrist for mediation management, so if issues arise, adjustments can be made. Furthermore, Petitioner is authorized for community outings twice per week for at least 30 minutes and it appears from the record that those outings are now happening on a regular basis, albeit with some changes due to COVID-19.

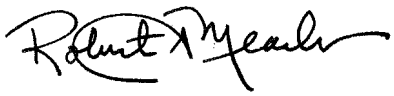
As such, based on the evidence presented, the CMH's decision was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Petitioner's request for increased Personal Care and Community Living Supports in an AFC home.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.



RM/sb

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
48913

Counsel for Petitioner

Simon Zagata
4095 Legacy Parkway, Suite 500
Lansing, MI
48911-4263
SZAGATA@drmich.org

Petitioner

[redacted], MI

DHHS Department Rep.

Stefanie Zin
CMHA-CEI
812 E. Jolly Rd., Suite 108
Lansing, MI
48910
zinst@ceicmh.org