

**STATE OF MICHIGAN  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

[REDACTED]

Appellant

\_\_\_\_\_ /

Docket No. 2009-22112 CMH  
Case No. [REDACTED]  
Load No. [REDACTED]

**DECISION AND ORDER**

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

After due notice, a hearing was held [REDACTED]. The Appellant is a ward of the State of Michigan and was represented by [REDACTED]. Present on behalf of the Appellant were [REDACTED] and [REDACTED].

[REDACTED], appeared on behalf of the [REDACTED], an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded community mental health supports and services (hereafter, 'Department'). Also appearing on behalf of the Department was [REDACTED].

**ISSUE**

Has the Department appropriately denied the Appellant's request for Medicaid-funded long-term residential placement?

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [REDACTED], ward of the State of Michigan and Medicaid beneficiary.
2. The Appellant is a client of [REDACTED].
3. The Appellant has been identified as a person with a serious emotional disturbance (e.g., bipolar disorder NOS and post-traumatic stress disorder).

*(Exhibit A, page 17)*

4. The Appellant has a multitude of behavioral problems that include sexual acting out, aggression, temper tantrums, knife hoarding, threatening other children and adults with knives and jumping from a window.
5. The Appellant has not been successfully placed into a foster care home due to his behavioral problems.
6. The Appellant was removed from his foster care home placement on ██████████, due to his extreme behavioral problems and placed into an inpatient psychiatric hospital.
7. The Appellant was deemed stable and ready for discharge from the hospital on ██████████. He has not been returned to foster care, or any other alternative placement.
8. The Appellant's Guardian Ad Litem, through the Department of Human Services, seeks long term residential placement of the Appellant and asserts this a Medicaid covered service that must be provided through ██████████.
9. The Appellant does not currently meet the psychiatric inpatient admission criteria for continued placement in crisis residential services.
10. The placement sought on behalf of the Appellant is long term residential placement.
11. ██████████ denied the request, made on the Appellant's behalf, for a 3-6 month residential therapeutic placement services. The reason for denial is that long term residential placement is not a Medicaid funded service.
12. In response to the ██████████, denial, the Appellant's guardian requested a formal, administrative hearing on ██████████.

### **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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [REDACTED] contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

The Code of Federal Regulations at *42 CFR 440.230* states that Medicaid beneficiaries are only entitled to medically necessary **Medicaid-covered** services, provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

The Medicaid Provider Manual, Mental Health/Substance Abuse chapter provides a listing of the Medicaid covered services [REDACTED] may provide. With regard to "covered services," Section 3 states, in pertinent part, as follows:

### **Section 3 - Covered Services**

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services.

Crisis Residential Services are Medicaid-covered services. The Medicaid Provider Manual, Mental Health/Substance Abuse chapter, details the eligibility requirements for this service:

### **SECTION 9 – Intensive Crisis Stabilization Services**

Intensive/crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can

reasonably be expected in the near future to result in physical harm to the individual or to another individual.

### **9.1 APPROVAL**

The PIHP must seek and maintain MDCH approval for the intensive crisis stabilization services in order to use Medicaid funds for program services.

### **9.2 POPULATION**

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay. Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

### **9.3 SERVICES**

Intensive/crisis services are intensive treatment interventions delivered by an intensive/crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);
- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

### **9.4 QUALIFIED STAFF**

Intensive/crisis services must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. The treatment team providing intensive/crisis stabilization services must be mental health professionals. Nursing services/consultation must be available. The treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists.

### **9.5 LOCATION OF SERVICES**

Intensive/crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

Exceptions: Intensive/crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

### **9.6 INDIVIDUAL PLAN OF SERVICE**

Intensive/crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive/crisis stabilization services treatment plan must be developed. The intensive/crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the services and activities designed to resolve the crisis and attain his goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved.

The role of the case manager must be identified, where applicable.

For children's intensive/crisis stabilization services, the treatment plan must address the child's needs in context with the family needs. Educational services must also be

considered and the treatment plan must be developed in consultation with the child's school district staff.

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The Appellant's guardian is requesting residential placement at a facility specializing in treating individuals with conditions similar to that of the Appellant. No particular facility has been identified as of the time of hearing. Much uncontested evidence was presented regarding the Appellant's behaviors and conduct. He has been dangerous in the recent past and is potentially dangerous in the future. He poses extreme challenges for any entity charged with his care and development. This is uncontested. The DHS witness cites as her reason why the Appellant needs treatment in a structured setting, his lack of successful foster care placement and need for treatment for longer than a few days. It was asserted that the few days offered for crisis residential placement followed by discharge back to foster care results in a return of extremely dangerous behaviors, thus a longer term residential placement is medically necessary. At the same time, the witness asserts the placement sought is not long term residential placement. While this ALJ may agree that a stay of several days may be insufficient to manage the challenges presented by the Appellant, the placement sought must first be a Medicaid funded service in order to make a determination that ██████████ is obligated to provide it.

██████████ asserts the length of stay sought on behalf of the Appellant is a long term residential placement, thus is not a Medicaid covered service. It cites the length of stay proposed as evidence that it is a long term residential placement. The proposed initial placement sought is for 3-6 months, according to the Department of Human Services worker. The DHS witness also characterized the placement time frame as an initial request. ██████████ cites the Medicaid Provider Manual inpatient admission criteria as support for the position that the placement sought is actually a long term residential placement. ██████████ witnesses assert that the Appellant does not satisfy any of the admission criteria at this time, thus his continued placement there is inappropriate and constitutes long term residential placement.

After review of the services authorized by the Medicaid Provider Manual, admission criteria and uncontested evidence of the Appellant's current mental/medical status, this ALJ concurs with the ██████████. The placement sought is a long term residential placement. It is not a Medicaid covered service. Both the length of stay proposed and its characterization as an initial request undermine any assertion that the proposed placement is not a long term residential placement. It is not for the purpose of managing an immediate crisis, or crisis stabilization. He has been stabilized and ready for discharge since ██████████, according to uncontested hospital records. The Policy specifies that the crisis residential placements are only for people who meet admission criteria for inpatient psychiatric facilities. While the Appellant offers ample evidence of a multitude of serious and profound behavioral challenges faced, the documentation of his current functioning and conduct does not support a finding he meets admission criteria for inpatient

psychiatric placement. The Appellant offers no evidence to refute [REDACTED] evidence that the Appellant does not currently meet inpatient admission criteria for psychiatric placement. This ALJ heard the testimony offered that the 3 to 6 month proposed initial placement does not constitute long term residential placement, however, disagrees. In contrast to the criteria for crisis stabilization, 3 to 6 months is long term residential placement. The Medicaid Provider Manual does not authorize a residential placement for this length of time as a Medicaid covered service. Such a placement may very well be the best placement for the Appellant, however, it is not a Medicaid covered service under current policy, thus [REDACTED] is not obligated to authorize the placement requested.

**DECISION AND ORDER**

Based on the above findings of fact and conclusions of law, I find that, based on current policy, [REDACTED] denial of placement in a long-term residential setting is appropriate.

**IT IS THEREFORE ORDERED** that:

[REDACTED] denial of Appellant's request for long-term residential placement is **AFFIRMED**.

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Jennifer Isiogu  
Administrative Law Judge  
for Janet Olszewski, Director  
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 7/23/2009

**\*\*\* NOTICE \*\*\***

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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.