[redacted]
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[redacted] **MI** [redacted]

Date Mailed: September 14, 2020
MOAHR Docket No.: 20-004856
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Corey Arendt**

## DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 *et seq*; 42 CFR 438.400 *et seq*; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on September 8, 2020. [redacted]d, Petitioner's father, appeared on behalf of Petitioner. [redacted], Petitioner's Therapist from Easter Seals and [redacted], Wraparound Facilitator from [redacted], appeared as witnesses for Petitioner. [redacted], Petitioner's Mother, observed the hearing. Andrew Brege, Attorney, appeared on behalf of Respondent, Oakland Community Health Network (Department). Steffany Wilson, Clinical Director, and Dr. Patricia O'Brien, Clinical Psychologist, appeared as witnesses for the Department. Benita Brown, Due Process Coordinator, and Jasmin White observed the proceeding.

Exhibits:

| | |
|---|---|
| Petitioner | None |
| Department | A – Hearing Summary |

## ISSUE

Did Respondent properly deny Petitioner's request for long-term state facility hospitalization?

## 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 Medicaid beneficiary, born [redacted] 2009. (Exhibit A, p 16.)

2. Petitioner has a history of removal and eventual termination of parental rights

due to allegations of neglect and multiple foster care placement related to disruptive behaviors and has been diagnosed with Reactive Attachment Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and a Mood Disorder. (Exhibit A, p 5.)

3. On May 4, 2020, Petitioner's mother indicated Petitioner had a good week and ended up having an emotional break through which never happens. (Exhibit A, p 33.)

4. On May 6, 2020, Petitioner had her last day of Face to Face. (Exhibit A, pp 43, 44.)

5. As of May 6, 2020, Petitioner was receiving home-based services, medication reviews, respite, wraparound services, and a yearly psychiatric examination. (Exhibit A, p 1; Testimony.)

6. On May 7, 2020, during an assessment, Petitioner's parents indicated Petitioner seemed to be doing very well and was emotionally in a good place. (Exhibit A, p 44.)

7. As of May 12, 2020, Petitioner was exhibiting signs of Post-Traumatic Stress Disorder (PTSD) and symptoms of Attention-Deficit Hyperactivity Disorder (ADHD). As of May 12, 2020, Petitioner was showing signs of improvement with current treatment strategies. (Exhibit A, pp 53, 61.)

8. On May 22, 2020, Petitioner submitted a request for State Facility placement. (Exhibit A, p 1; Testimony.)

9. On May 27, 2020, PREST denied Petitioner's May 22, 2020 request for State Facility placement. (Exhibit A, pp 1, 11-13; Testimony.)

10. On June 11, 2020, Petitioner's family submitted a local level appeal. (Exhibit A, p 1; Testimony.)

11. On July 1, 2020, a Local Appeal Closing/Resolution letter was issued following a 2nd level review. The letter affirmed the May 27, 2020 decision to deny State Facility placement. (Exhibit A, pp 1-10; Testimony.) The letter specifically stated the following:

> When the PREST State Facility denial was made, the Easterseals outpatient services were clinically appropriate given the beneficiary's condition at the time the denial was made. When the State Facility denial was made Easterseals was providing clinically appropriate services including coordination of care with family on status at ER, coordination with partial programming when she was in partial programing prior to the ER, coordination with school, participation in Wraparound meetings and therapy w/[redacted]

approximately 2 times per week when she was at home. While she was in the ER, the crisis plan was reviewed, wraparound meetings continued and Easterseals staff continued to participate and coordinate services. During the time [redacted] was in the ER home based therapy services were not able to be provided.

The IPOS/Plan adequately address the beneficiary's concerns regarding the need for State Facility. IPOS Goal 2 states, "Increase and practice ability to manage anger prior to becoming physically aggressive." The objectives for this goal include parenting techniques, Penny learning to express herself verbally and physically, CLS, Home-Based Services, Respite, Wraparound and summer camps/socialization. The primary reason the family is requested [sic] state facility is physical aggression.

When the 5-27-20 denial was made of state facility [redacted] had appropriate amount, scope, and duration to reasonably achieve the goals in the plan with the authorized services in place in her IPOS including:

- Home Based Services 1.5 hours/week
- Medication Reviews 1/month
- Respite services 20 hours/week
- Wraparound 2 hours/month
- Psychiatric Evaluation 1/year

[redacted] did not have current CLS authorizations or services in place on 5/27/20, however, the family and Easterseals were coordinating to restart services. Per note on 4/24/20, CLS will begin via telehealth and per Wraparound Meeting on 5/7/20 "she would begin CLS services with her grandpa beginning on Saturday."

…

- It is recommended that CLS services be authorized and provided as described in current IPOS.
- It is recommended that Crisis Plan be reviewed and rehearsed with family at least one time per

month with whole family and all CLS/Respite providers (Crisis Planning and Prevention Protocol).

- It is recommended that alternatives to police involvement be explored in crisis planning and therapy sessions with parents.

- It is recommended that coordination of care be continued with all providers and supports.

- It is recommended to continue to offer a FASD assessment.

- It is recommended to complete a Functional Behavioral Assessment (Assessment Protocol) and a positive behavior plan be implemented after assessment is completed.

- It is recommended to continue to offer Parent Support Partner Services[.]

- It is recommended that all services and support be continued to be provided as authorized in the plan of service.

- It is recommended that home-based therapy services continue to be provided more than one time per week in shorter session lengths to support attention span and needs of the family.

- It is recommended to provide evidence-based parenting training such as PMTO or through a group format, PTC. (Exhibit A, pp 5-6, 9.)

12. On July 30, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing.

## CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.[1]
>
> 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.[2]

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…[3]

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 (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

The Mental Health Code defines a person requiring treatment:

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[1] 42 CFR 430.0.
[2] 42 CFR 430.10.
[3] 42 USC 1396(b).

**330.1401 "Person requiring treatment" defined; exception.**

Sec. 401.

(1) As used in this chapter, "person requiring treatment" means (a), (b), or (c):

(a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

(c) An individual who has mental illness, whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

(2) An individual whose mental processes have been weakened or impaired by a dementia, an individual with a primary diagnosis of epilepsy, or an individual with alcoholism or other drug dependence is not a person requiring treatment under this chapter unless the individual also meets the criteria specified in subsection (1). An individual described in this subsection may be hospitalized under the informal or formal voluntary hospitalization provisions of this chapter if he or she is considered clinically suitable for hospitalization by the hospital director.

The MDHHS Medicaid Provider Manual (MPM) addresses 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.[4]

In this case, Petitioner is seeking placement at a long-term State Facility hospital due to a history of escalating violence over several years and multiple inpatient hospital stays and intensive outpatient programs. Petitioner specifically indicated the current treatment regimen is not working and more is needed.

The Respondent argued the denials were appropriate because a less restrictive setting in the community with support services authorized in the appropriate amount, scope, and duration can meet Petitioner's needs. Therefore, Petitioner did not meet the criteria for long-term state facility hospitalization. The Respondent specifically indicated that inpatient admission may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility and where the youth is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability that is either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.[5] The Department indicated that was not the case here. After reviewing the evidence presented, I agree with the Respondent.

The evidence indicates the Petitioner may be treated in a less restrictive setting and that there are several services that are not being utilized by the Petitioner that could alleviate the Petitioner's issues/concerns. Specifically, the Petitioner has not been utilizing allocated CLS services or undergone a Functional Behavioral Assessment or FASD assessment, nor has the Petitioner created/adopted a behavior plan in accordance with the Functional Behavioral Assessment. Each of these services when used in conjunction with other services currently being provided may reasonably allow Petitioner

[4] Medicaid Provider Manual (MPM), Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, April 1, 2020, pp 14-15.
[5] See MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, April 1, 2020, p 62, and Dr. O'Brien's testimony.

to achieve her goals and avoid the need for an inpatient admission.[6]

Given the evidence and applicable policies in this case, Petitioner has not met her burden of proof regarding the Respondent's determination to deny Petitioner's request for long-term in-patient hospitalization. At that time, it appears that a less restrictive setting in the community with support services authorized in the appropriate amount, scope, and duration could meet Petitioner's needs. Accordingly, Department's determination to deny Petitioner's request for long-term in-patient hospitalization is upheld.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly denied Petitioner's request for long-term state facility hospitalization based on the information available at that time.

**IT IS THEREFORE ORDERED** that

The Department's decision is AFFIRMED.

CA/dh

**Corey Arendt**
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

[6] Both of Petitioner's witnesses, Ms. Martin, and Ms. Whitton, agreed, that Petitioner may benefit from a behavioral plan.

**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

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|---|---|
| **DHHS Department Rep.** | Benita Brown - 63<br>Oakland Community Health Network<br>5505 Corporate Drive<br>Troy, MI 48098 |
| **DHHS -Dept Contact** | Belinda Hawks<br>320 S. Walnut St.<br>5th Floor<br>Lansing, MI 48913 |
| **Counsel for Respondent** | Andrew Brege<br>822 Centennial Way, Suite 270<br>Lansing, MI 48917 |
| **Petitioner** | [redacted]<br>[redacted]<br>[redacted] MI [redacted] |
| **Authorized Hearing Rep.** | [redacted]<br>[redacted]<br>[redacted] MI [redacted] |