[redacted]
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Date Mailed: August 21, 2020
MOAHR Docket No.: 20-003606
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 August 13, 2020. The August 13, 2020 hearing was adjourned on the record due to Respondent not seeing the Notice of Hearing (it was placed in the wrong file) and continued on August 20, 2020. [redacted] and [redacted], Petitioner's parents, appeared and testified on Petitioner's behalf. Marcia Vansoelen, Supports Coordinator appeared at the August 13, 2020 hearing but not at the hearing on August 20, 2020.

Anthony Holston, Assistant Vice President of Appeals & Grievances, appeared and testified on behalf of Respondent, Beacon Health Options, the PIHP for Network 180. (CMH or Department). Amy Prinsmorofsky, Appeals and Grievance Coordiantor, also appeared on behalf of Respondent. Alison Mace, Assistant Liaison for State Psychiatric Facilities, Network 180, appeared as a witness for Respondent.

ISSUE

Did the CMH properly deny Petitioner's request for specialized residential placement?

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 March 1, 2004, receiving services through Network 180, the Community Mental Health agency for [redacted] County, Michigan. (Exhibit A, p 51; 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. (Exhibit A; Testimony)

3. Petitioner is diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder, and Intellectual Developmental Disorder, Moderate to Severe. (Exhibit A, pp 33, 53; Testimony).

4. Petitioner currently lives with his parents and three siblings. (Exhibit A, p 33; Testimony).

5. Petitioner attends [redacted] School. Petitioner has 1:1 support but has his own separate room at school that he spends most of his time in due to his on-going aggressive behaviors throughout the school day. Petitioner engages in constant aggressive behaviors, despite consistent interventions. (Exhibit A, p 52; Testimony)

6. Petitioner is non-verbal and cannot read or write. Petitioner needs assistance with dressing, bathing, toileting, brushing his teeth and meal preparation. Petitioner can independently put his clothes on and off with prompting, but he is not capable of zipping, buttoning, or tying. Petitioner is mobile and is capable of walking, jogging, jumping, and climbing stairs independently. Petitioner enjoys going for walks, playing with sand, playing with sensory balls or throwing balls and doing puzzles. (Exhibit A, pp 34-35; Testimony).

7. Petitioner requires 1:1 supervision in the kitchen, the home and the community. Petitioner has a history of hurting peers and damaging household walls and objects when triggered. (Exhibit A, pp 36-37; Testimony)

8. Petitioner has been hospitalized multiple times in the past few years due to his behaviors: February 2, 2018 – February 16, 2018 (Harbor Oaks); May 10, 2018 - May 17, 2018 (Harbor Oaks); July 23, 2018 – September 7, 2019 (Harbor Oaks); October 1, 2018 – October 29, 2018 (Harbor Oaks); February 19, 2019 – March 18, 2019 (Harbor Oaks); August 13, 2019 – August 26, 2019 (Harbor Oaks); November 24, 2019 – December 4, 2019 (Helen Devos). (Exhibit A, p 52; Testimony)

9. Since the COVID-19 pandemic began in March 2020, Petitioner's parents have been afraid to take Petitioner to the hospital due fear of Petitioner contracting COVID-19. (Testimony)

10. Petitioner has been receiving the following services through CMH through the Children's Home and Community-Based Services Waiver (CWP): Children's Waiver Program, Targeted Case Management, Respite, and Community Living Supports. (Exhibit A, p 39; Testimony)

11. Since before Petitioner's IPOS review in September 2019, Petitioner's parents have requested that Petitioner be placed in a residential facility such as Hawthorn to provide Petitioner medication management and to decrease his aggressive behaviors of physically hurting others in the family home and being destructive at home by punching holes in the walls and breaking objects. (Exhibit A, p 38; Testimony)

12. The family attended a Complex Case Review in March 2019 at which time it was suggested that a Hawthorn Pre-Admission Worksheet be completed to determine if Petitioner was eligible for placement at Hawthorn. Upon review, Petitioner was denied placement at Hawthorn. (Exhibit A, p 38; Testimony)

13. On February 20, 2020, the family attended another Complex Case Review following further requests for residential placement for Petitioner. It was noted that Petitioner has been in and out of the hospital various times over the years due to his aggressive and destructive tantrum behaviors. Petitioner will rush/run up to people, chase people, and try to hit them. Petitioner will also try to choke others. These behaviors occur multiple times daily and the family is often unable to intervene due to Petitioner's large size and fear of being injured (Petitioner is currently close to 400 pounds). (Exhibit A, p 51; Testimony)

14. Following the Complex Case Review on February 20, 2020 it appears as if the team made the same recommendations as the team did in March 2019, including a Pre-Admission Worksheet for Hawthorn. (Exhibit A, p 54; Testimony)

15. Petitioner's family has been unable to find a residential placement facility that will accept Petitioner and take the family's insurance. (Exhibit A, p 51; Testimony)

16. On February 24, 2020, CMH sent Petitioner's parents a Notice of Benefit Determination, denying Petitioner's request for Hospitalization at Hawthorn Center and/or Residential Mental Health Treatment because such placement was not the least restrictive setting at the time. The Notice also include recommendations for further services in the community that Petitioner's parents could consider. (Exhibit A, pp 29-32; Testimony)

17. On April 6, 2020, Petitioner's parents requested an internal appeal. (Exhibit A, pp 26-28; Testimony)

18. On April 23, 2020, CMH sent Petitioner's parents a Notice of Appeal Denial, indicating that the internal appeal had been denied. (Exhibit A, pp 11-25; Testimony)

19. On June 9, 2020, Petitioner's Request for Hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1)

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with MDHHS 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 applicable sections of the Medicaid Provider Manual (MPM) provide:

> **2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP**
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> 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. (Emphasis added)
>
> **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, p 15
Emphasis added

SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)

The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.

The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.

Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social

worker with consultation by a building specialist and an occupational therapist.

14.1 KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP “pre-screen” form and sending it to the MDHHS to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child’s waiver services. The case manager, the child and his family, friends, and other professional members of the planning team work cooperatively to identify the child’s needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children’s waiver service per month in order to retain eligibility.

14.2 ELIGIBILITY

The following eligibility requirements must be met:

- The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.

- The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.

- The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

- <u>The child is at risk of being placed into an ICF/IID facility because of the intensity of the child’s care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home</u>.

- The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

- The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

14.3 COVERED WAIVER SERVICES

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

Community Living Supports

Community Living Supports (CLS) provides assistance to a 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; 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. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.

The CMHSP must maintain the following documentation:

- A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.

- Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.

All service costs must be maintained in the child's file for audit purposes.

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Respite Care Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year.

The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 95-100
Emphasis added

SECTION 6 – CRISIS RESIDENTIAL SERVICES

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to

avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

Individuals who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life including relationships, where to live, training, employment, daily activities, and physical well-being.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless 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. The program must include on-site nursing services (RN or LPN under appropriate supervision). On-site nursing must be provided at least

one hour per day, per resident, seven days per week, with 24-hour availability on-call.

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6.5 LOCATION OF SERVICES

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

6.6 ADMISSION CRITERIA

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

6.7 DURATION OF SERVICES

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

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Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 46-48
Emphasis added

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.

- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

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8.5.C. INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care 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. The SI/IS criteria for admission are based on the assumption that the child, youth, or young adult is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)

At least **one** of the following manifestations is present:

- Severe Psychiatric Signs and Symptoms

    - Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.

- Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.

- Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.

- Disruptions of Self-Care and Independent Functioning

  - Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.

  - The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.

- Harm to Self

  - A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.

  - There is a specific plan to harm self with clear intent and/or lethal potential.

  - There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.

  - There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.

  - There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.

  - There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

- Harm to Others

- Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.

- There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.

- There has been significant destructive behavior toward property that endangers others, such as setting fires.

- The person has experienced severe side effects from using therapeutic psychotropic medications.

- Drug/Medication Complications or Coexisting General Medical Condition Requiring Care

  - The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.

  - There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.

Intensity of Service The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following:

- Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

- Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

- Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

- A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

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Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 57-64

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

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9.2 CHILDREN'S SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

A crisis situation means a situation in which at least one of the following applies:

- The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.

- The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.

- The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.

- The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.

The goals of intensive crisis stabilization services are as follows:

- To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning;

- To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth 's functioning ability;

- To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;

- To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and

- To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.

9.2.A. APPROVAL

The PIHP must seek and receive MDHHS approval, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.2.B. POPULATION

These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face to face contact in one hour or less in urban

counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.

9.2.C. SERVICES

Component services include:

- Assessments (rendered by the treatment team)
- De-escalation of the crisis
- Family-driven and youth-guided planning
- Crisis and safety plan development
- Intensive individual counseling/psychotherapy
- Family therapy
- Skill building
- Psychoeducation
- Referrals and connections to additional community resources
- Collaboration and problem solving with other child- or youth-serving systems, as applicable
- Psychiatric consult, as needed

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9.2.E. LOCATION OF SERVICES

Intensive crisis stabilization services must be provided where necessary to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment.

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

- Inpatient settings;
- Jails or detention centers; or
- Residential settings (e.g., Child Caring Institutions, Crisis Residential).

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Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2020, pp 67-70
Emphasis added

CMH's Assistant Liaison for State Psychiatric Facilities (ALFSPF) testified that she is a Master's level Social Worker who has been in her position for approximately five years. CMH's ALFSPF testified that she is responsible for monitoring and coordinating admissions to Michigan's five regional psychiatric hospitals for Network 180. CMH's ALFSPF indicated that she reviewed Petitioner's medical records and denied his request for admission to Hawthorn Center, a state psychiatric hospital, because Petitioner did not meet Medicaid's inpatient psychiatric hospital criteria. CMH's ALFSPF noted that there are immense restrictions at psychiatric hospitals due to the acuity of person's admitted and, according to policy, Petitioner must be in the least restrictive environment. CMH's ALFSPF also indicated that the CMH must exhaust every other community setting option before being referred to a state psychiatric hospital.

CMH's ALFSPF also testified that Hawthorn is not a long-term residential placement setting but rather a hospital. CMH's ALFSPF indicated that a hospital is for short term stabilization of patients before they are transferred to the community while residential settings are for persons who are chronically acute and need long-standing care. CMH's ALFSPF testified that on April 6, 2020 Petitioner was not an immediate threat to himself or others and he had not exhausted all other options for community services. CMH's ALFSPF testified that most persons entering Hawthorn first meet inpatient hospitalization criteria at a regular hospital before being transferred to a psychiatric hospital and here, Petitioner was at home in April 2020. CMH's ALFSPF noted that it appeared as if Petitioner's parents were seeking long-term residential treatment or placement for Petitioner and long-term residential treatment is not a service that CMH can authorize. CMH's ALFSPF testified that long-term residential placement must be covered by a family's insurance and is not a service CMH can approve because CMH is not authorized to pay for long-term residential placement. CMH's ALFSPF indicated that she was pleased to hear that Petitioner underwent a Complex Care Review at Network 180 as that was one of the community services she recommended.

Petitioner's mother testified the family requested Hawthorn because that was recommended at the Complex Care Review. Petitioner's mother indicated that they also requested placement for Petitioner at Great Lakes Center for Autism (Great Lakes), who assessed Petitioner and determined that he would be a good fit, but Network 180 denied the placement, finding that it was not a covered service. Petitioner's mother testified that the family's insurance will also not pay for Great Lakes and they cannot afford the cost on their own. Petitioner's mother reviewed Petitioner's hospitalizations over the years. Petitioner's mother testified that Petitioner is now [redacted] years old and this has been going on since Petitioner was diagnosed with Autism Spectrum Disorder at age 13. Petitioner's mother noted that the local hospitals Petitioner has been admitted to over the years tell her that there is nothing more they can do for Petitioner.

Petitioner's mother testified that Petitioner has other siblings in the home and their lives have been halted as they just try to keep themselves, and Petitioner safe. Petitioner's mother indicated that Petitioner's aggressive behaviors come out of nowhere and even at school Petitioner has to be kept in a separate room because of his behaviors. Petitioner's mother noted that she cannot even drive Petitioner alone in the car as she needs someone there in case Petitioner becomes agitated. Petitioner's mother testified that Petitioner has been in ABA therapy on and off since age 13 and his behaviors have not improved. Petitioner's mother noted that because Petitioner is home all the time now due to COVID-19 he wants to eat all the time. Petitioner's mother indicated that if Petitioner does not get what he wants he starts pounding on things, putting holes in walls and breaking furniture. Petitioner's mother testified that they just want Petitioner to be safe. Petitioner's mother indicated that they are not looking for long-term placement for Petitioner but rather a short-term placement where Petitioner's medications can be reviewed, and he can be stabilized. Petitioner's mother testified that they will take him back home once he is more stable. Petitioner's mother testified that because of Petitioner's size and weight (he is close to [redacted] pounds now) he is in great danger of hurting himself and others.

Petitioner's father testified that Respondent's witness should have known about all of Petitioner's past hospitalizations but did not seem to. Petitioner's father noted that records of those hospitalizations are in Petitioner's medical records for all to see. Petitioner's father also noted that Hawthorn was requested because that is what was recommended at the Complex Case Review. Petitioner's father testified that he believes the conclusion reached by CMH is improper and based on incomplete information. Petitioner's father also referred to the letter from Dr. Stanton that recommends Petitioner be placed in residential treatment. (Exhibit 1). Petitioner's father also noted that Petitioner almost had to be hospitalized yesterday because Petitioner's blood sugar was close to 500.

Petitioner has the burden to prove, by a preponderance of the evidence, that the CMH's decision to deny inpatient psychiatric hospitalization and/or long-term residential treatment was improper. Based on the evidence presented, Petitioner has failed to meet that burden. Under the Department's medical necessity criteria section, there exists a more clinically appropriate, less restrictive and more integrated setting in the community for Petitioner, specifically his own home. As noted above, "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."

Here, Petitioner has been screened for placement at Hawthorn on two separate occasions and on both occasions, it was determined that Petitioner did not meet the criteria for admission. And while Petitioner has been hospitalized numerous times in non-psychiatric hospitals, at the time of the most recent review in February and April 2020, Petitioner did not meet that criteria. Petitioner can be effectively treated in outpatient mental health treatment with increased intensity of ABA services, a patient support partner for the family, occupational therapy, a sensory management plan,

respite services, and a supports coordinator to assist the family with concerns around medication effectiveness and side effects during medication evaluation. Furthermore, Petitioner has a limited ability to utilize services offered in residential mental health treatment, such as group and individual therapy. And, while Petitioner's doctor does support residential mental health treatment for Petitioner, the doctor is not tasked with evaluating and assessing Medicaid beneficiaries for such treatment. That task is assigned to the CMH and CMH staff have expertise in the area. Finally, as indicated above, while inpatient psychiatric hospitalization, crisis residential services and intensive crisis stabilization services are available to Medicaid beneficiaries, long-term residential services are not contracted for by the CMH.

Petitioner bears the burden of proving by a preponderance of the evidence that specialized residential placement is a medical necessity in accordance with Medicaid policy and the Code of Federal Regulations (CFR). Petitioner did not meet the burden to establish that such placement is a medical necessity.

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 placement at Hawthorn Center and/or specialized residential placement.

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-Location Contact
DHHS Department Rep.

Anthony Holston
Beacon Health Options/Appeals
Coordinator
48561 Alpha Dr Ste 150
Wixom, MI
48393

DHHS -Dept Contact

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

Authorized Hearing Rep.

[redacted]
MI

Authorized Hearing Rep.

[redacted]
MI

Petitioner

[redacted]
MI