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

Date Mailed: May 10, 2021
MOAHR Docket No.: 21-001350
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 April 28, 2021. The hearing could not be completed in the allotted time and the hearing was later continued May 5, 2021. [redacted], Petitioner's father, appeared on Petitioner's behalf. [redacted], [redacted], and [redacted] appeared as witnesses for Petitioner. Stacy Coleman-Ax, Chief Compliance Officer, appeared on behalf of Respondent, Macomb County Community Mental Health (Department).

ISSUE

Did the Department properly deny Petitioner's request for specialized residential placement at Hawthorn Center?

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] 2005, receiving services through the Department. Petitioner's approved services include Community Living Supports (CLS), Respite, Medication Review, Individual Therapy, Family Therapy, and Parent Support. (Exhibit A, pp 1, 14; Testimony.)

2. Department 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 emotionally impaired and diagnosed with unspecified

disruptive mood disorder, impulse control disorder, ADHD, depressive disorder, and conduct disorder. (Exhibit A, p 13; Exhibit 2, p 296; Testimony.)

4. Prior to July 2020, Petitioner was placed at a residential youth facility. (Testimony.)

5. In or around July 2020, the residential youth facility closed, and Petitioner was released to his home. (Testimony.)

6. Between July 2020 and October 2020, Petitioner has assaulted his family on several occasions, has been arrested, and has had several short-term residential placements. (Testimony.)

7. On September 28, 2020, Petitioner's father requested Petitioner be placed at Hawthorn Center. (Exhibit A, p 13; Testimony.)

8. On October 6, 2020, Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated the request for State Hospitalization was denied but that Petitioner should be considered for placement in a residential facility through the Department of Health and Human Services (DHHS). (Exhibit A, p 2; Testimony.)

9. On November 24, 2020, Petitioner submitted to Respondent, a request for an internal appeal. (Exhibit A, pp 8, 13.)

10. On December 8, 2020, Respondent sent Petitioner a Notice of Appeal Denial and a copy of Findings and Recommendations. (Exhibit A, pp 8-15.) The Documents stated in part:

> We denied your internal appeal for the service/item listed above because: After review, the Medical Director has determined that the medical necessity of long term placement at Hawthorn is not supported. It is recommended that his mental health needs can be met in a less restrictive setting. **See attached summary for detail**…[1]
>
> After review, the Medical Director has determined that the medical necessity of long term placement at Hawthorn is not supported. It is recommended that his mental health needs can be met in a less restrictive setting, and that, as a teenager, he would benefit from a program that provides more community involvement than a hospital can provide. It is recommended that placement at a DHHS residential

[1] Exhibit A, p 8.

> facility should be considered as an alternative to returning to the parental home.[2]

11. On March 17, 2021, MOAHR, received from Petitioner, a request for hearing. (Exhibit 1, p 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.[3]
>
> 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.[4]

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)

[2] *Id* at 15.
[3] 42 CFR 430.0.
[4] 42 CFR 430.10.

> 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…[5]

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.[6]

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**
>
> 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

[5] 42 USC 1396n(b).
[6] 42 CFR 440.230.

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.[7]

****

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

[7] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2020, p 15.

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.

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.[8]

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SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric

[8] *Id* at 47-49.

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.

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.[9]

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SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

[9] *Id* at 58, 63-65.

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 [CHANGE MADE 10/1/20]

The PIHP must seek and receive MDHHS approval through an enrollment process, (text added 10/1/20) 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

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 other settings where the beneficiary has been adjudicated; or
- Residential settings (e.g., Child Caring Institutions, Crisis Residential).[10]

The Department's witness testified that Petitioner's request for admission to Hawthorn Center, a state psychiatric hospital, was denied, because Petitioner did not meet Medicaid's inpatient psychiatric hospital criteria. The witness went on to indicate Petitioner was stable from a psychiatric standpoint as he did not need medication changes/monitoring and that it was his behavioral problems that created the issues now at issue. The Department insisted Petitioner could be treated in a less restrictive setting but may benefit from placement at a DHHS residential facility.

[10] *Id* at 68, 70-72.

§8.5.C above addresses in-patient admission criteria for children at facilities like Hawthorn. §8.5.C lays out several different circumstances and criteria that would qualify a child for in-patient admission. The criteria indicate admission is based on the assumption that the child 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. The policy goes on to indicate the Petitioner must meet the following three criteria: (1) the beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis, (2) the beneficiary has one of the following manifestations present; severe psychiatric signs and symptoms; disruptions of self-care and independent functioning; harm to self; harm to others; or drug/medication complications or coexisting general medical condition requiring care, and (3) the beneficiary meets intensity of service requirements.

The evidence does not suggest Petitioner was denied services because he failed to meet the first criteria. Thus, it can be reasonably assumed or inferred that Petitioner suffered from a mental illness reflected in a primary, validated, and current version of DSM or ICD.

For the second criteria, the beneficiary must have one of the listed manifestations present. In this case, based upon the testimony and the exhibits presented, Petitioner likely has manifestations of severe psychiatric signs and symptoms and harm to others. Petitioner has grown increasingly violent towards a sibling and his parents as well as exhibits extreme agitation that results in bizarre behavior affecting his daily living. The evidence also shows that Petitioner's current level of care fails to resolve these issues.

Lastly, to be eligible for in-patient admission, Petitioner must meet the intensity of service requirements. Again, based upon the evidence presented, it appears the Petitioner requires continuous observation and control of behavior to protect his family members so that treatment may occur.

The current services being offered are not accomplishing their intended goal of resolving Petitioner's issues or even of keeping him stable. It is clear, the Petitioner cannot be in his family home at this time and that being there is a trigger that results in outbursts and violence towards others. Placement of some kind outside the home appears to be medically necessary.[11] As a result, I find sufficient evidence to reverse the Department's decision to deny in-patient admission at Hawthorn.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department improperly denied Petitioner's request for placement at Hawthorn Center.

[11] This might be in the form of crisis residential services or an in-patient admission or even a combination of crisis residential services and intensive crises stabilization services.

IT IS THEREFORE ORDERED that:

The Department decision is REVERSED.

The Department is to reassess Petitioner and determine whether Petitioner is eligible for crisis residential services, or intensive crises stabilization services, or in-patient admission at Hawthorn.

CA/dh

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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

Authorized Hearing Rep.

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DHHS-Location Contact

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