STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-02/10-42
	)	
Appeal of	)	

INTRODUCTION

The petitioners, D.R. and M.R., are the parents of a fifteen year old child, R.R., who presents with complex and interrelated mental health, neurological, and learning issues. The petitioners adopted R.R. as a special needs child when he was an infant.

Both the petitioners and the Department of Mental Health (DMH) agree that R.R. needs a residential therapeutic placement. The petitioners appeal the decision by the DMH denying the funding for an out-of-state residential placement. The DMH found that an in-state residential placement is appropriate for R.R.

R.R. receives Medicaid. Payment for a residential placement will be paid through the Medicaid program under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The issue is whether R.R. meets the criteria for medical necessity under the EPSDT program for placement at an out-of-state residential program.

Procedural History

Petitioners filed their request for fair hearing on February 2, 2010. A telephone status conference was held on March 4, 2010. The DMH internal review was pending. The case was scheduled for another status conference on April 5, 2010 and a tentative hearing date of April 12, 2010. Petitioners notified the Board on March 16, 2010 that the internal review upheld the DMH's decision not to fund an out-of-state placement and the case could proceed to hearing; arrangements were being made to depose a witness who was not available on the hearing date.

A fair hearing was held on April 12, 2010. The parties submitted Stipulated Facts and Stipulated Documents. The parties submitted extensive post-hearing briefs.

The decision is based on the evidence and legal arguments of the parties.

FINDINGS OF FACT

1. The Stipulated Facts and Stipulated Documents are incorporated herein and attached as Exhibit A.

Witnesses

2. The petitioners M.R. (mother) and D.R. (father) became R.R.'s foster parents when he was ten days old. The Department for Children and Families (DCF) placed R.R. with petitioners after removing R.R. from his home when he was an infant. R.R.'s biological mother used alcohol and drugs while pregnant with R.R. Petitioners adopted R.R. when he was an infant.

3. Petitioners have been and are proactive in seeking services for R.R. and help for their family in meeting the challenges of a child with many special needs. R.R.'s treating doctor and therapist credit R.R.'s progress to the petitioners' persistence in maximizing services for R.R.

Petitioners periodically used the services of K.K., an educational consultant, to identify and locate programs for R.R. K.K. identified a number of out-of-state placements including the Chamberlain School in Massachusetts where R.R. is presently receiving services at the petitioners' cost.

Petitioners would prefer an in-state placement but do not believe that the DMH referrals meet R.R.'s therapeutic needs.

4. Dr. B.F. wrote in support of placing R.R. in a residential placement and testified at deposition. She

supports the petitioners' position that R.R. be placed at Chamberlain School. Her views will be more fully set out later in the findings.

5. Dr. B.F. became R.R.'s treating pediatrician when he was three years old. She has treated R.R. for twelve years. Dr. B.F. is a pediatrician at FAHC (Fletcher Allen Health Care) with twenty-five years experience in Burlington. She recently served five years on the Task Force on Mental Health for the American Academy of Pediatrics whose members were charged with addressing best practices for pediatric mental health.

6. Dr. B.F. diagnosed R.R. with Fetal Alcohol Effect (FAE) when he was three years old. Her diagnosis was later confirmed by the Boston Children's Hospital who also found global developmental delays.[1]

7. R.N. testified at hearing in support of petitioners' position. R.N. is a licensed masters therapist. He provided mental health counseling to R.R. for approximately three years. He provided therapy for R.R. from January 2007 through August 2009 when he was employed at the community mental health center. R.N. next provided therapy

[1] Based on the most recent I.Q. testing, R.R. has a full-scale I.Q. of 75.

to R.R. in his private practice from October 2009 until February 2010 when R.R. left for the Chamberlain School.

8. L.O. is the Clinical Care Coordinator for Children and Adolescents at DMH. She has a Masters degree in counseling. She is the liaison with several community mental health agencies. She is part of the CRC (Case Review Committee).[2] She testified on behalf of DMH at hearing.

9. L.O. is familiar with R.R. because she is the DMH contact for R.R.'s local inter-agency team and because his CRC referral came to her. The local inter-agency team was charged with assessing R.R.'s needs and identifying services for R.R. L.O. has never met R.R.

10. P.S. is the Director for Adult Mental Health Services at DMH. She has a medical degree but does not presently practice medicine. P.S. oversaw the internal review that denied funding for an out-of-state placement for R.R. P.S. testified on behalf of DMH at hearing.

11. P.S. has not met R.R. She familiarized herself with the case by reading all the materials and meeting with

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[2] Act 264 addresses the needs of children with severe emotional disturbance by stressing coordination and cooperation between DMH, Vermont Department of Education, DCF-Family Services Division, and others through the creation of a State Interagency Team (SIT). 33 V.S.A. §§ 4301 *et seq.* The SIT created the CRC to work with local teams who do the work of identifying services, etc. for individual children.

petitioners. The internal review concluded on March 10, 2010 that there was no evidence that in-state treatment was inadequate or inappropriate.

12. DMH policy favors in-state placement when residential care is necessary, but children will be placed out-of-state if their circumstances merit such a placement.[3] Both L.O. and P.S. point to evidence-based studies supporting the use of residential placements within the child's home area because there are normally better outcomes of reintegrating the child into his/her home environment when the residential placement is local.

13. Neither L.O. or P.S. is conversant with the EPSDT requirements of the Medicaid program and how those requirements apply to R.R.'s placement.

14. L.O. and P.S. testified that DMH's decision is not based on cost and L.O. testified that the cost to DMH of the Chamberlain School may be less than the cost of in-state residential placement.[4]

[3] DMH has not promulgated regulations under the Vermont Administrative Procedures Act. Instead, they have written policies dealing with residential placements.

[4] Although DMH has not placed children at the Chamberlain School, DCF has placed children in DCF custody at the Chamberlain School at Medicaid expense.

15. The lack of resources, in particular, residential placements in Vermont impacts on crafting programs for adolescents with mental health needs.

R.R. experiences increasing difficulties with the onset of adolescence

16. Dr. B.F. said that she saw R.R. go downhill despite everyone's best efforts. According to Dr. B.F., R.R.'s mood and behavior problems increased with the onset of puberty. She explained in writing that this phenomenon is seen in boys diagnosed with FAE.

17. Over the past few years, R.R. has experienced increasing suicidal ideation, self-harming behaviors such as cutting, and harming his family and peers. R.R.'s suicidal ideation includes hearing voices telling him to kill himself.

18. R.R. was admitted to an e-bed (emergency bed) at Jarrett House in September 2008 due to suicidal ideation.

19. R.R.'s next e-bed admission was from May 22 to June 1, 2009 at NFI's Hospital Diversion Program.[5] He was admitted through First Call (an emergency service) due to suicidal and homicidal ideation. R.R. had specific suicide plans.

[5] NFI is a private nonprofit agency that provides a range of services including emergency beds, treatment in the home and community, and residential treatment.

20. In the discharge planning from the NFI e-bed, the parties identified the need for additional supports but were not clear what steps should be taken. The discharge plan stated:

> A plan was developed to make concurrent referrals to IFBS (intensive family based services), DAP (diagnostic assessment program), NFI or Baird home wrap, and a private summer residential program.

In addition, the discharge plan recommended review of all past assessments to help address an appropriate treatment plan and prognosis. The discharge plan noted that R.R. responds best to highly structured and predictable services including significant one on one attention.

21. A DAP referral could not be put into place until August 2009 and called for placing R.R. with a therapeutic foster family for sixty days. The petitioners were concerned that this process could be problematic for R.R. because he moves around in the evening and self-harms and because of the need to transition from middle school to high school at the end of the summer.

22. The petitioners were offered a summer program consisting of eight days of camp and one week with R.N. The petitioners did not think this was sufficient.

23. The petitioners placed R.R. at Wediko for forty-five days in the summer. Wediko has a forty-five-day therapeutic summer program for special needs children ranging in age from eight to eighteen. M.R. testified that Wediko has a 1:1 therapeutic setting. They attended family therapy once/week. The petitioners used Wediko in place of the DAP and summer program offered to them.

24. T.B. is a MA Licensed Psychologist employed by NFI-Outpatient Clinical Services. She undertook the review recommended in the above discharge plan. She reviewed all of R.R.'s assessments and materials, interviewed M.R., and issued a report on July 7, 2009. She wrote that her goal was to give information to those working with R.R. about interventions and services.

25. T.B. paid particular attention to an April 2007 Neuropsychological evaluation by Dr. S.S. T.B. found that professionals and family working with R.R. should become familiar with this report to better understand R.R.'s functioning. T.B. incorporated the following information:

> Dr. [S.S.] reports "Clinically [R.R.] presents with a complicated array of psychiatric problems that are consistent with several interconnected diagnoses that are difficult to separate. This multi-faceted social-emotional-behavioral profile involves highly salient conduct problems, developmentally inappropriate inattention and hyperactivity/impulsivity, oppositional-

> defiance, mood disturbance, features of anxiety, and attachment issues. [R.R.] also displays many of the attributes exhibited by students who have been exposed to alcohol in utero, these being learning struggles, social perceptual problems, poor capacity for abstraction, impaired executive functions, memory weakness, hyper activity, attention problems, disruptiveness, need for constant supervision, and disregard for rules and authority.
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> . . .
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> Dr. [S.S.] recommends a "multimodal wraparound medical/psychiatric and psychosocial approach to treatment" within a "structured and supportive environment directed specifically to his needs."

T.B. recommended that R.R. receive extensive wrap-around support and that he would benefit from Neurosequential Model of therapies.

26. In addition to T.B.'s recommendations, the petitioners provided evidence regarding R.R. through their testimony, testimony of R.R.'s treatment providers, and documentary evidence that provides additional information to be used to put together residential services:

a. R.R. needs consistency across environments.

b. R.R. has difficulty reading social cues. R.R. did not have friends within his home school district although R.R. made friends at the Wediko summer program and has friends at his present placement at the Chamberlain School.

c. R.R. is developmentally behind his peers by two to four years. He was described as an innocent who still believed in Santa when he was fourteen years old.

d. R.R. has concrete thinking.

e. R.R. has been bullied in school settings.

f. R.R. wants to fit in and have friends. He has lied to impress others. Others can easily manipulate him, which puts him at risk for problem behavior.

g. R.R. has brought contraband (small weapons) to school.

h. R.R. has trouble with transitions.

i. R.R. needs to process in the moment.

Events leading to recommendation for residential placement

27. The petitioners and Dr. B.F. observed R.R. upon his return from Wediko. R.R. made friends at Wediko. He was happier and more relaxed.

28. The petitioners believed that the summer would allow services to be put in place for R.R.

29. IFBS started by September 2009. Other services were in place except for a therapist for R.R. after R.N. left the community mental health center at the end of August 2009 and except for family counseling because the community mental health center was unable to find a counselor with an opening.

30. R.R. started to crash upon his return to school. R.R. did not want to go to school; he was absent on many occasions and often late because of the difficulty petitioners had getting him up and to school. On September

15, 2009, R.R. cut himself at school. Cutting himself at school was an escalation in his behaviors. There were a total of four crisis situations in the fall of 2009 at school.

31. On or about September 8, 20009, the IFBS team recommended NFI intensive in-home wrap around services. Wraparound service planning started on September 22, 2009. As R.R.'s condition worsened, the IFBS team added NFI-Shelburne House (a residential placement) to the mix.

32. NFI-Shelburne House is a three bed residential placement for youth with severe mental health, behavioral and/or developmental challenges. There is a 1:1 staff/youth ratio. The youth range in age from twelve to eighteen and stay on average from one to two years.

33. NFI-Shelburne House did not have any available beds.[6]

34. The petitioners experienced a crisis with R.R. on or about November 7,2009. M.R. described R.R. escalating his suicidal behaviors. The petitioners wrestled a knife out of R.R.'s hand. R.R. then broke a mirror and was going to hurt himself with a shard of glass but the petitioners were able

[6] There was evidence that NFI-Shelburne House had been discussed earlier but was not available as an option.

to get the shard of glass away from him. The incident led to an Act 264 meeting.

35. Petitioners felt that they could no longer keep R.R. safe. They did not want to use the CHINS (child in need of supervision) process and have R.R. declared unmanageable and placed under DCF custody. They made the decision that R.R. needed a residential placement.

36. On November 17, 2009, the petitioner wrote to L.O. and to J.E.[7] requesting a residential treatment and educational program. The petitioners explained that R.R. was on a downward slide and they did not have the ability or energy to stop this slide. They identified the November 7, 2009 suicide attempt as the most serious suicide attempt and the tipping point for them.

37. R.R.'s local inter-agency team recommended residential placement for R.R. on or about November 18, 2009.

38. The petitioners' request for a residential placement for R.R. was supported in writing by letters from Dr. A.H. and from Dr. B.F.

[7] J.E. is the superintendent of the local school district.

Dr.A.H. is R.R.'s treating psychiatrist. She supported a residential placement with intensive treatment and wraparound services.

Dr. B.F. wrote that she did not think the petitioners or the school could guarantee R.R.'s safety. She recommended a specialized residential program that incorporated contact and socialization with peers.

39. The request for residential placement triggered a review by the State Interagency Team (SIT). L.O. provided technical assistance.

The SIT through the CRC determines whether residential placement is appropriate. If residential placement is appropriate, they look at the Vermont programs that are the best match for the child. Placement can be made out-of-state.

40. R.R. was approved for residential placement. L.O. sent referral letters on or about November 30, 2009 to both the NFI group home and NFI-Shelburne House.

Out of state placement request

41. Space was not available at NFI-Shelburne House. At all times relevant to this case, the NFI-Shelburne House was not a realistic option.

42. Petitioners were encouraged to contact P.C., group home director, at the NFI group home.

43. The NFI group home has six beds and the youth attend public school.[8] Three girls were in residence. The average stay is nine months. The services are not as intensive as NFI-Shelburne House.[9]

44. Petitioners met with P.C. on or about December 18, 2009. M.R. testified that P.C. told them that the group home had a group therapy milieu and a psychiatrist present once per month. At night, two staff members were present with one awake at any given time. The petitioners were worried that night staffing was not sufficient because R.R. can be out of control at night. The petitioners were worried that R.R. would have difficulties given his developmental delays and were concerned about the transition and communication between the NFI group home and R.R.'s school. The petitioners believe that P.C. agreed that R.R.'s needs were too complex for the group home.

45. On December 19, 2009, P.C. e-mailed L.O. that the NFI group home was not the best option although it was a local option. He wrote:

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[8] The NFI group home is not in the same school district as the petitioners and R.R., although it appears that R.R. would have been able to stay in his home district.

[9] The services for each program can be accessed at www.nafi.com. Use the link for Vermont.

> Perhaps if mom and dad were fully invested it would be worth a try, but even then his needs would require us to individualize to the limits of our ability to be flexible and that would be with limited ability to predict successful outcomes. Given that his needs are significant at this time, that his functional level socially and intellectually is more limited than our current milieu and that his parents are hesitant, it seems most appropriate to look at other programs.

46. L.O. asked P.C. for a written denial letter. L.O. spoke to the director of NFI's children unit. L.O. then received an e-mail on December 22, 2009, from P.C. that after a conversation with C.M., they "discussed the need for RR to be served in state, as per CRC and DMH." P.C. wrote they could accept R.R. as a placement. P.C.'s turnaround is predicated on State preference for residential placements in-state, not a different analysis of R.R.'s needs or the suitability of the NFI group home program for R.R.

47. The petitioners were informed on or about December 22, 2009 in a letter from P.C. that NFI approved the referral and R.R. was placed on the waitlist. The petitioners were surprised to receive this notification.

48. On or about December 24, 2009, the petitioners wrote L.O. that they did not believe that the NFI group home had the ability to create the type of individualized program across all settings that R.R. needed. They requested an out-of-state placement and listed four possible programs.

49. The SIT upheld the decision to place R.R. at the NFI group home. The petitioners asked for an internal review on or about February 10, 2010. The internal review was denied on March 10, 2010. P.S. testified that the main reason for the denial is that they look for in-state services.

50. P.S. testified that her knowledge of NFI is based upon what she has read and heard.

51. L.O. testified that the NFI programs are highly skilled with children with complex needs and have good coordination with local schools.

52. The petitioners placed R.R. at the Chamberlain School when a placement became available in February 2010.

53. M.R. testified that they talk to R.R. daily. The petitioners receive a daily report from Chamberlain School that they can process with R.R.

They've visited several times; other family members have also visited R.R. The petitioners speak to R.R.'s case manager/therapist several times per week. R.R. is supervised around the clock. M.R. described Chamberlain as a therapeutic and special education residential program. R.R. receives a continuum of care and consistency of care across all settings.

54. Dr. B.F. saw R.R. when he was home for a visit after six weeks at Chamberlain School. R.R. described a typical day. He sees his therapist daily. He is in a setting where there are similar children. R.R. reported that he made friends and has a girlfriend. Dr. B.F. described a child whose demeanor and attitude were improved.

55. Dr. B.F. does not support NFI-Group Home as a placement. She has had other patients placed at NFI-Group Home in the past, but these patients' condition and needs differed from R.R.'s condition and needs. Her patients were placed there for ten days to three months due to out of control behavior; their residence at the NFI group home gave the opportunity to do therapy while programming was put in place in the community.

Dr. B.F. stated that the social piece is crucial for R.R., meaning the need to make connections with peers and to function in society. To make this happen, R.R. needs seamless services. Based on her knowledge of the program, she does not believe that it is appropriate for R.R.

56. Dr. B.F.'s main concern is that R.R. be in a situation in which there is consistency across settings. R.N. concurs and in written material (exhibit 22) pointed to the need for "consistent interventions with tighter

supervision". He also stated that R.R. needs to be with his peers.

Both support Chamberlain School. Their knowledge about Chamberlain School is based upon the information provided by the parents. Dr. B.F. has additional information based on R.R.'s report and based on her observations of R.R.

ORDER

The DMH's decision is reversed.

REASONS

Petitioners adopted R.R. as a special needs baby. R.R. is now fifteen years old. R.R. presents many challenges to the petitioners, his treatment providers, his peers, the school system, and others due to the interrelated nature and severity of his neurological, mental, and learning disabilities. His diagnoses include Fetal Alcohol Effect FAE), Attention Deficit Hyperactivity Disorder, Global Development Delay, an anxiety disorder, a mood disorder, a receptive-expressive language disorder, and Reactive Attachment Disorder.

The facts underscore how R.R. spiraled downward after the onset of puberty even after the petitioners and service providers intensified their efforts to meet his increasing

needs. R.R.'s continuing deterioration led the petitioners to place R.R. in an out-of-state residential placement during their administrative appeals.

The issue is not whether R.R. needs residential placement. The parties do not dispute that R.R.'s need for residential placement meets the criteria for medical necessity and do not dispute that Medicaid will provide the requisite funding.

The dispute stems from the petitioners' request that DMH authorize Medicaid funding for R.R.'s out-of-state residential placement.

The petitioners followed the requisite procedures specified by DMH when they made their request. DMH denied the petitioners' request and found that the NFI-group home is adequate to meet R.R.'s needs.

DMH policy favors in-state placement. DMH points to research that supports the use of residential placement in or close to the youth's home. DMH believes that the NFI group home is adequate to meet R.R.'s needs. The petitioners maintain that DMH's decision is not consistent with the requirements of the Early Periodic Screening, Diagnosis, and Treatments (EPSDT) requirements of the Medicaid program to do

an individualized review that leads to treatment that maximizes the benefit for the recipient.

Before addressing the specifics of this case, the EPSDT requirements will be set out.

State participation in the Medicaid program is voluntary. However, once a state elects to participate in the Medicaid program, the state must comply with federal statutory and regulatory requirements. 42 U.S.C. § 1396. Jacobus v. Dept. of PATH, 177 Vt. 496 (2004), Cushion v. Dept. of PATH, 174 Vt. 475, 477 (2002)(mem.).

Congress took special care to provide for the needs of children as part of the Medicaid program. In particular, Congress mandated that States participating in the Medicaid program provide EPSDT services to the children. 42 U.S.C. §§ 1396(d)(a)(13) and 1396d(r)(5).

The pertinent sections of 42 U.S.C. § 1396d(a)(13) requires States to provide EPSDT-eligible children with:

> . . .other diagnostic, screening, preventive, and rehabilitation services including any medical or remedial services (provided in a facility, home or other setting) recommended by a physician or other licensed professional of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best functional level. (emphasis added).

The intent is to provide medically necessary services to EPSDT recipients. Rosie D. v. Romney, 410 F.Supp.2d 18, 25 (D.Mass. 2006); Collins v. Hamilton, 349 F.3d 371, 372 (7th Cir. 2003); John B. v. Menke, 176 F.Supp.2d 786, 800 (M.D. Tenn. 2001); Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Servs., 293 F.3d 472, 480 (8th Cir. 2002).

The Vermont Medicaid regulations incorporate the expansive nature of the EPSDT program by the following language in W.A.M. § 4100:

> The scope of coverage for children under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Title XIX is different and more extensive than coverage for adults. The EPSDT provisions of Medicaid law specify that services that are optional for adults are mandatory covered services …when such services are determined necessary…Specifically, Vermont is required to provide
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>> . . .such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of [1396d] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan. 42 U.S.C. § 1396d(r)(5).
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> A further definition of the scope of EPSDT services is found in 42 U.S.C. § 1396d(a)(13). . .

See Fair Hearing Nos. 20,816; 21,077; Y-01/09-24; and B-02/09-94.

The crux of the problem is that the EPSDT requirements were not integrated into how DMH made this decision. DMH did not consider the intent of the EPSDT program to maximize the benefits of treatment which can include the maximum reduction of mental disability. Instead, DMH looked at what they considered as adequate. Because DMH did not consider the EPSDT requirements in their decision, their decision to refer R.R. to the NFI group home cannot stand.

The referral to the NFI group home raises other issues given the evidence that the placement, per se, did not meet the EPSDT requirements. DMH witnesses describe the NFI group home program as adequate. Adequacy alone does not meet the EPSDT requirements for maximum reduction of mental disability or restoration of the child to the best functional level.

The petitioners' testimony and initial e-mail correspondence from P.C. to L.O. support the conclusion that the NFI group home would not only be stretched to their limits dealing with R.R.'s constellation of problems and needs but could not guarantee positive outcomes. P.C.'s change of heart is tied to state policy favoring in-state residential care not to the specifics of R.R.'s case.

In addition, R.R.'s medical providers do not support placing R.R. at the NFI group home. Both Dr. B.F. and R.N.

have spoken to the importance not only of consistency across settings but placing R.R. in a milieu where he is with his peers. Deference should be given to their opinion based on their knowledge and familiarity of R.R. Urban v. Meconi, 930 A.2d 860, 865 (Del.S.Ct. 2007).

The question is one of relief. The petitioners have submitted a compelling case for the Chamberlain School as medically necessary based on their experience with the Chamberlain School and the reports of R.R.'s experience at the school. R.R. is receiving wraparound services with intensive counseling and support as well as consistency across settings. Consistency across settings prevents undermining the impact of services. R.R. is with peers and experiencing social success; doing so takes away a stressor that affected him in his home setting. DMH can assess and monitor R.R.'s continuing and future needs for residential placement at the Chamberlain School.

Based on the foregoing, DMH's decision is revered. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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