[redacted], MI [redacted]

Date Mailed: September 2, 2020
MOAHR Docket No.: 20-004129
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on August 4, 2020. [redacted], Petitioner's grandmother/adoptive mother, appeared and testified on behalf of the minor Petitioner. [redacted], Petitioner's Case Manager at Training and Treatment Innovations (TTI), also testified as a witness for Petitioner. Leslie Garrisi, Access Center Supervisor, appeared and testified on behalf of the Respondent Macomb County Community Mental Health.

During the hearing, Petitioner's Request for Hearing was entered in the record as Exhibit #1, pages 1-2. Respondent also submitted an evidence packet that was admitted into the record as Exhibits A, pages 1-42.

ISSUE

Did Respondent properly deny Petitioner's request for targeted case management?

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 who has been diagnosed with reactive attachment disorder; post-traumatic stress disorder; and attention deficit/hyperactivity disorder, primarily inattentive presentation. (Exhibit A, pages 7, 28).

2. He also presents with anxiety, aggressiveness, inattention, difficulties staying on task, and difficulties following instructions. (Exhibit A, pages 16-17, 28).

3. In April or May of 2019, Petitioner requested services through Respondent. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

4. That request was denied on the basis that Petitioner did not meet criteria for services through Respondent. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

5. During a private psychological evaluation completed on August 29, 2019, Petitioner scored within the low average range in verbal comprehension, working memory, and processing speed; the average range in verbal acquisition; borderline significant in the emotional reactive, anxious/depressed, and pervasive developmental section; clinically significant in withdrawn and affective problems; and low average in communication section. (Exhibit A, page 14).

6. The recommendations for Petitioner from that psychological evaluation were for home therapy; caregiver counseling/supports; family counseling; supports coordination; psychiatry monitoring; and respite care. (Exhibit A, page 14).

7. Petitioner is enrolled in a Medicaid Health Plan (MHP), but no behavioral or mental health services have been requested through his MHP. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

8. Petitioner does receive behavioral services through the elementary school he attends. (Exhibit A, page 14).

9. Services were also subsequently requested through Respondent again. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

10. On December 11, 2019, Petitioner was assessed for services through Respondent. (Exhibit A, pages 7-36).

11. In the Initial Intake completed that day, it was noted that Petitioner has minimal natural supports and the support he does have, *i.e.* his mother, has her own health issues. (Exhibit A, page 14).

12. The intake also found that Petitioner's CAFAS score places him on the tier of behavioral problems with moderate mood disturbance. (Exhibit A, page 14).

13. Petitioner is able to express his basic wants and needs or answer simple questions when asked and prompted by his mother, but he needs assistance with grooming, monitoring his medications, eating, and toileting. (Exhibit A, pages 14, 33).

14. He also requires step-by-step instructions to complete a task and he has minimal safety and stranger danger awareness; poor insight; and an unawareness of the consequences of his actions. (Exhibit A, pages 14, 17).

15. He further requires 24/7 supervision to monitor for health and safety. (Exhibit A, page 33).

16. In the Initial Intake, and based on the above findings, Respondent admitted Petitioner for services. (Exhibit A, page 35).

17. It was also noted that Petitioner was requesting Community Living Supports, respite care services, case management, speech therapy, occupational therapy, physical therapy, psychiatry services, and behavioral services. (Exhibit A, page 35).

18. Respondent then approved Petitioner for targeted case management, with TTI as the service provider, on a limited basis while any further necessary assessments were completed and requests or referrals for specific services were made. (Exhibit A, page 36; Testimony of Respondent's representative).

19. TTI completed an intake and uploaded all documentation, but it did not refer Petitioner to any therapist or have him assessed further. (Testimony of Case Manager).

20. On January 17, 2020, Petitioner, through TTI, requested targeted case management, medication reviews and treatment planning through Respondent. (Testimony of Respondent's representative).

21. The requests for medication reviews and treatment planning were subsequently approved. (Testimony of Respondent's representative).

22. On January 28, 2020, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that Respondent was denying Petitioner's request for targeted case management because Petitioner did not appear to meet the criteria for the services based upon a review of the Medicaid Provider Manual (MPM), Petitioner's CAFAS, and the intake completed in December of 2019. (Exhibit A, pages 1-6).

23. On June 29, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding Respondent's decision. (Exhibit #1, pages 1-2).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *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…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner requested targeted case management services through Respondent. With respect to that service, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 13 – TARGETED CASE MANAGEMENT**
>
> Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. For children and youth, a family driven, youth guided planning process should be utilized. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.
>
> Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.
>
> Beneficiaries must be provided choice of available, qualified

case management staff upon initial assignment and on an ongoing basis.

* * *

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.

- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.

- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.

- Identifying and addressing gaps in service provision.

- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.

- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.

- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.

- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.

- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.

- Assisting beneficiaries with crisis planning.

- Identifying the process for after-hours contact.

MPM, January 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
pages 92-93

While targeted case management is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or

- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

- that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- that are experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MPM, January 1, 2020 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
pages 14-15

Here, as discussed above, Respondent decided to deny Petitioner's request for targeted case management. Petitioner then requested the administrative hearing in this matter with respect to that decision.

In support of the denial, Respondent's Access Center Supervisor testified that, while Petitioner meets the criteria for services through Respondent and was authorized for medication reviews and treatment planning, the request for targeted case management was denied on the basis that it was not medically necessary. Specifically, she noted that, while Petitioner is a minor, he has a guardian who can manage and coordinate his services. She also noted that treatment services are not hindered by the lack of a case manager, as providers can make any necessary referrals, and that TTI is mistaken if it believed targeted case management needed to be approved ongoing in order for other services to be requested. The Access Center Supervisor agreed that most lay people, like Petitioner's mother, might not know what services are available, which is why

Respondent approved treatment planning and targeted case management through TTI for 60 days while Petitioner was assessed and linked to providers and services.

In response, Petitioner's representative testified that she understands Respondent's decision, but that she disagrees with it. She also testified that she needs help, as she has been trying to get Petitioner services for 8 months; she has been hitting brick walls; and she does not know what else to do. Specifically, Petitioner's representative testified that she wants behavioral therapy, a case manager and respite care services for Petitioner, but that all have been denied. She further testified that the whole process has been nothing but confusing and that having a case manager again would be beneficial.

Petitioner's Case Manager at TTI testified that, while Petitioner's representative wants behavioral therapy, a case manager and respite care services for Petitioner, only targeted case management was actually requested because TTI believed that the other services could not be requested unless targeted case management was reauthorized. She also testified that, after Petitioner received case management on a temporary basis, he went through TTI's intake and documentation was uploaded, but that no other assessments or referrals were made, in part because Petitioner's representative did not want outpatient therapy.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

As a preliminary matter, the undersigned Administrative Law Judge would note that, while Petitioner's representative asserted that she was appealing the denial of requests for multiple services, including behavioral therapy and respite care services, it is undisputed that the only requested service that was denied by Respondent was targeted case management and, consequently, that is the only negative action at issue in this case and the only denial that will be reviewed.

Targeted case management assists beneficiaries in designing and implementing strategies for obtaining services and supports, and it must be available for all children with serious emotional disturbance who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from Respondent, and/or are unable to independently access and sustain involvement with needed services.

Here, Petitioner is a child with a serious emotional disturbance, but he also has an adult guardian who is able to independently access and sustain involvement with needed

services, especially given his enrollment in an MHP and his treatment through a pediatrician, and nothing in the record demonstrates a high level of vulnerability. Moreover, given the limited services that were requested through Respondent following the past approval for targeted case management, it does not appear that Petitioner either had multiple services needs or required access to a continuum of mental health services through Respondent.

To the extent Petitioner's circumstances have changed or he has additional information to provide in support of a need for more services, then he can always submit another request for more services in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for targeted case management.

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sb

Steven Kibit
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 -Dept Contact

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

DHHS-Location Contact

David Pankotai
Macomb County CMHSP
22550 Hall Road
Clinton Township, MI
48036

Petitioner

[redacted], MI

Authorized Hearing Rep.

[redacted], MI

Agency Representative

Tracy Dunton, M.A. LPC
6555 15 Mile Road
Sterling Heights, MI
48312