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Date Mailed: October 21, 2020
MOAHR Docket No.: 20-005961
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 was held on October 20, 2020. [redacted], Nurse Practitioner (NP) appeared and testified on Petitioner's behalf.

Anthony Holston, AVP, Appeals and Grievances appeared on behalf of Respondent, Beacon Health Options (Respondent or CMH). Amy Prins, Senior Appeals Coordinator, Beacon Health Options; and Mehgan McNeil, Utilization Management Program Manager, Network 180, appeared as witnesses for the CMH.

ISSUE

Did CMH properly deny Petitioner's request for continued Targeted Case Management (TCM)?

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 [redacted], who is diagnosed with borderline personality disorder, generalized anxiety disorder, major depressive disorder, and post-traumatic stress disorder. (Exhibit A, pp 15, 23; Testimony)

2. Petitioner resides with her father in a two-bedroom apartment in [redacted], Michigan. (Exhibit A, p 15; Testimony)

3. Petitioner frequently suffers from anxiety and panic attacks, resulting in social isolation and struggles completing community requirements.

(Exhibit A, p 15; Testimony)

4. On June 2, 2020, Petitioner underwent a Biopsychosocial Assessment at Cherry Health, a contracted provider for Network 180 where Petitioner receives mental health services, including outpatient therapy and medication management. (Exhibit A, pp 23-33; Testimony).

5. On July 6, 2020, Petitioner's Individual Plan of Service (IPOS) was completed, to be effective August 1, 2020. (Exhibit A, pp 15-22; Testimony)

6. As part of the IPOS process, Petitioner and her case manager requested that Petitioner's services, including Targeted Case Management (TCM), be continued. (Exhibit A, p 15; Testimony)

7. On July 22, 2020, CMH sent Petitioner a Notice of Adverse Benefit Determination informing Petitioner that her request for Targeted Case Management was denied. (Exhibit A, pp 11-14); Testimony)

8. On July 30, 2020, Petitioner filed a request for a Local Appeal. (Exhibit A, pp 8-10; Testimony)

9. On August 28, 2020, following the Local Appeal, the CMH sent Petitioner a Notice of Appeal Denial informing her that the denial of her request for Targeted Case Management was being upheld. (Exhibit A, pp 2-7; Testimony)

10. On September 23, 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 Department of Health and Human Services (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Health and Human Services to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- 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; 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.

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
July 1, 2020, pp 12-14

Case Management services are also defined in the Medicaid Provider Manual:

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. 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.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

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.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2020, pp 82-84

CMH's Utilization Management Program Manager (UMPM) testified that she manages the Utilization Management department at Network 180 where they complete clinical

review to determine if medical necessity criteria are met for specific programs and services, such as TCM. CMH's UMPM testified that she is familiar with Petitioner's case and had reviewed Petitioner's clinical record. CMH's UMPM indicated that Petitioner is currently authorized to receive outpatient therapy and medication management through the CMH. CMH's UMPM testified that TCM is intended for persons with Serious Mental Illness (SMI) who have multiple service needs and a high degree of vulnerability. CMH's UMPM noted that such persons are in need of mental health services but are unable to access and maintain services on their own.

CMH's UMPM indicated that in Petitioner's case the clinical record was reviewed looking for evidence of assistance with linking Petitioner to care and connecting Petitioner to services to maintain her independence in the community. However, CMH's UMPM testified that in the documentation submitted there was no evidence of such linking or coordination of care. CMH's UMPM noted that Petitioner has a stable living arrangement as she lives with her father, has access to healthcare, and follows up with her providers on her own. CMH's UMPM noted that Petitioner is usually not interested in medications for her mental illness, but she is compliant with taking medication on her own when it is prescribed. CMH's UMPM also noted that Petitioner is actively engaged in outpatient therapy and this service has been most impactful for her. CMH's UMPM testified that there is no evidence that Petitioner has ever been in a psychiatric hospital or received crisis residential services, which is something that is looked for when reviewing requests for TCM. CMH's UMPM noted that if Petitioner had been psychiatrically hospitalized within the past two years, the request for TCM would not have been denied. Based on this review, CMH's UMPM indicated that it was determined that TCM was not medically necessary for Petitioner.

Petitioner's Nurse Practitioner (NP) testified that she has known Petitioner for five years and serves as Petitioner's Primary Care Provider at Catherine's Health Center. Petitioner's NP testified that she is a graduate of Calvin College and MSU and has a master's degree in nursing. Petitioner's NP testified that both she and Petitioner believe Petitioner needs TCM. Petitioner's NP noted that in November 2019 Petitioner underwent orthopedic surgery for significant ankle issues and following the surgery developed a pain disorder. Petitioner's NP indicated the Petitioner was then referred to Mary Free Bed for pain management and Spectrum Health for physical therapy. However, Petitioner's NP indicated that because COVID hit in March 2020 Petitioner was unable to attend the physical therapy. Petitioner's NP testified that in April 2020 Petitioner was seen by a podiatrist who referred her to Pine Rest. At that time, Petitioner's NP testified that she did not know Petitioner was working with CMH (through Cherry Health) and attending counseling. Petitioner's NP testified that since COVID-19, Petitioner has been presenting with difficult physical issues which impair her ability to reach out to and engage in services. Petitioner's NP noted that Petitioner has also been referred to a pulmonologist, who referred Petitioner for speech therapy. Petitioner's NP indicated that Petitioner also has reflux disease which affects her sleep. Petitioner's NP testified that during video visits with Petitioner during the pandemic, Petitioner is in bed, in her pajamas watching television. Petitioner's NP admitted that it is her responsibility as Petitioner's PCP to coordinate Petitioner physical health needs,

but that her facility takes a holistic approach and seeks to assist patients with their social functioning as well.

In response, CMH's UMPM pointed out that Petitioner is still authorized to receive outpatient therapy and the individual therapist would be responsible for linking Petitioner with medication management services, if she needs them. CMH's UMPM also indicated that Petitioner's therapist will continue to assess Petitioner's needs and if her needs change or there is a crisis a new assessment for TCM could be conducted.

In her request for hearing, Petitioner indicated that she feels more unstable and is struggling more now than ever and could have benefited from these services if they were properly available. Petitioner testified that her case manager was often unavailable, and she had to look elsewhere for assistance. Petitioner indicated that she has a lot of health issues and has difficulty managing all of the paperwork with that, especially on the health and medicine side of things. Petitioner testified that most days she has a difficult time getting out of bed.

Based on the evidence presented, CMH properly denied Petitioner's request for continued TCM services. As indicated, TCM is intended for persons with Serious Mental Illness (SMI) who have multiple service needs and a high degree of vulnerability. Such persons need mental health services but are unable to access and maintain services on their own. Here, there was little to no evidence of such linking or coordination of care regarding mental health services with Petitioner. Petitioner has a stable living arrangement as she lives with her father, she has access to healthcare, and follows up with her providers on her own. Petitioner is usually not interested in medications for her mental illness, but she is compliant with taking medication on her own when it is prescribed. Petitioner is actively engaged in outpatient therapy and there is no evidence that Petitioner has ever been in a psychiatric hospital or received crisis residential services.

While it does appear that Petitioner has a number of physical health conditions that require coordination, Petitioner has healthcare and her PCP works with her to coordinate that care. Should Petitioner's condition worsen or should she have some sort of crisis, her need for TCM can be reevaluated. However, based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the CMH erred in denying her continued TCM services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied Petitioner's continued Targeted Case Management services.

IT IS THEREFORE ORDERED that:

The CMH's 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

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