[redacted]
MI [redacted]

Date Mailed: November 13, 2020
MOAHR Docket No.: 20-006231
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 November 10, 2020. Petitioner, [redacted], appeared and testified on their own behalf. Christina White, Case Manager, appeared as a witness for Petitioner.

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 Rebecca Palmer-Hornvook, Utilization Review Specialist, 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 anxiety, autism spectrum disorder, borderline personality disorder, and depression complicated by substance abuse. Petitioner identifies as gender fluid and non-binary and prefers to be called "Jay". (Exhibit A, pp 20, 23-25; Testimony)

2. Petitioner lives alone in Section 8 public subsidy housing. Petitioner's father is their representative payee. (Exhibit A, p 29; Testimony)

3. Petitioner is a high school graduate and has taken some classes at Grand Rapids Community College. (Exhibit A, p 29; Testimony)

4. Petitioner has been in recovery from marijuana and alcohol abuse through the SMART recovery program since March 2019, but Petitioner has used substances since that time. (Exhibit A, p 37; Testimony)

5. On July 31, 2020, Petitioner underwent a CRS Individual/Family Pre-Plan assessment (IPOS) at Pine Rest, a contracted provider for Network 180 where Petitioner receives mental health services, including case management, nursing services, psychiatric services, peer services, and therapy. (Exhibit A, pp 22-39; Testimony).

6. Petitioner's provider also included copies of Petitioner's progress notes with the request for reauthorization. (Exhibit A, pp 40-106; Testimony)

7. At the conclusion of the assessment process, Petitioner and their case manager requested that Petitioner's services, including Targeted Case Management (TCM), be continued. (Exhibit A, p 38; Testimony)

8. On September 4, 2020, CMH sent Petitioner a Notice of Adverse Benefit Determination informing Petitioner that their request for Targeted Case Management was denied. (Exhibit A, pp 16-19); Testimony)

9. On September 15, 2020, Petitioner filed a request for a Local Appeal. (Exhibit A, p 11; Testimony)

10. On September 29, 2020, following the Local Appeal, the CMH sent Petitioner a Notice of Appeal Denial informing them that the denial of their request for Targeted Case Management was being upheld. (Exhibit A, pp 4-10; Testimony)

11. On October 6, 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 Review Specialist (URS) testified that as a review specialist she uses Medicaid Provider Manual criteria to review and authorize requested services, including TCM. CMH's URS testified that she has worked in the field for about 25 years in several roles, including as a case manager and a therapist. CMH's URS indicated that Petitioner is diagnosed with generalized anxiety disorder, depressive disorder, autism spectrum disorder and had been receiving the Case Management package of services, which includes case management, nursing services, psychiatric services, peer services, and therapy. CMH's URS testified that looking at Petitioner's Individualized Plan of Service (IPOS) she noted that Petitioner's goals did not have any interventions specifically for case management. CMH's URS noted that most of the documentation included with the IPOS included therapy notes, not notes regarding any case management activities. CMH's URS indicated that upon review of the record she determined that a step down from the case management package would be appropriate for Petitioner. CMH's URS indicated that Petitioner would still receive all the other services they had been receiving but would no longer receive case management.

CMH's URS explained that case management involves a lot of linking and coordinating the beneficiary with services in the community, such as housing, employment and education, but it did not appear from the records that Petitioner needed any such linking or coordination at this time. CMH's URS noted that Petitioner's housing was stable, they did not need any linking with school or employment, and Petitioner was already set up with a primary care physician. CMH's URS also noted that Petitioner's last psychiatric hospitalization was in 2016.

Petitioner testified that they could not really understand why TCM was being cut off. Petitioner indicated that they spent the past year working on their physical health and their housing. Petitioner agreed that they had not been looking for assistance with employment or college in the past year, but they had used case management numerous times over the past year, including 10 times in January 2020. Petitioner testified that during that period there was talk of putting them in a psychiatric hospital and their case manager helped them significantly during this period. Petitioner also testified that they need case management services to work with CMH regarding CLS services because it is difficult for them to deal with CMH.

Petitioner testified that they are still working on their physical health and are having surgery later in the week of the hearing. Petitioner indicated that their last hospital stay

in 2016 had a little bit to do with a medical issue and being on pain medication and they are worried about the upcoming surgery because they will likely be on pain medication following the surgery. Petitioner indicated that they also planned to use case management to become their own payee but had a few other things to work on first with their family, who is responsible for a lot of their stuff. Petitioner testified that if they lost their case management services, they would have to rely more on their family, which would not be a good situation. Petitioner testified that there have been three instances this year where there was talk about putting them in a mental hospital. Petitioner indicated that they would prefer not to go into the mental hospital but there was so much talk in January that they had their bags packed.

Petitioner's Case Manager testified that she is Petitioner's case manager at Pine Rest, she has 13 years of experience, and has been working with Petitioner since 2015. Petitioner's Case Manager indicated that Petitioner has made a lot of progress over the past years, but Petitioner has had some new struggles over the last year or two. Petitioner's Case Manager testified that she is really worried how Petitioner will fare, especially during the COVID-19 pandemic. Petitioner's Case Manager testified that she believes part of the lack of usage of case management during the past year actually has to do with the COVID-19 pandemic. Petitioner's Case Manager testified that last year Petitioner had an infestation in her home, and she was involved extensively helping Petitioner link and coordinate with the homeowner and services to get the infestation cleared. Petitioner's Case Manager testified that because Petitioner lives in Section 8 housing, she needs assistance each year to complete the annual paperwork. Petitioner's Case Manager testified that coordinating Petitioner CLS with CMH also requires a lot of coordination as there is a lot of staff turnover and the services can be unreliable. Petitioner's Case Manager pointed out that Petitioner was actually without CLS for a short period of time because of the infestation. Petitioner's Case Manager testified that it was very difficult to get CLS reestablished and she provided a lot of assistance to Petitioner.

Petitioner's Case Manager testified that for reauthorization, she usually just sends the last few Progress Notes, which in this case were mostly from the therapist. Petitioner's Case Manager also noted that some things had just been worked out for Petitioner through case management prior to the reauthorization request so it is difficult to walk away from Petitioner wondering if they have the stability they need. Petitioner's Case Manager testified that it is hard to ask a therapist to do the amount of linking and coordination that Petitioner needs as that type of work is outside of their scope. Petitioner's Case Manager noted that while there has been more consistent engagement in therapy, there have also been a lot of no shows and Petitioner needs follow up and coordination for those instances. Petitioner's Case Manager testified that Petitioner also has a goal of becoming her own payee and she would need the assistance of a case manager to accomplish that goal. Petitioner's Case Manager testified that while Petitioner's IPOS does not include a specific goal to monitor Petitioner for health and safety, team members do monitor for that, as well as helping Petitioner overcome barriers. Petitioner's Case Manager testified that Petitioner's

substance abuse is still a struggle, is something Petitioner needs a lot of support with, and is not resolved.

Based on the evidence presented, Petitioner has proven, by a preponderance of the evidence, that CMH erred in denying 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 evidence of such linking or coordination of care regarding mental health services with Petitioner in the reauthorization request reviewed by CMH. Specifically, Petitioner has a goal in their IPOS of becoming their own representative payee and that is clearly not something that Petitioner would be able to accomplish on their own without a case manager. (Exhibit A, p 23.) The undersigned also takes notes of the fact that the documentation submitted with the reauthorization request encompasses a time exclusively during the COVID-19 pandemic, where it would be expected that Petitioner, as well as everyone else in society, was less engaged with the community. (Exhibit A, pp 22-110.) It does not appear that CMH considered this fact when deciding not to authorize Petitioner's continued TCM.

In addition, while Petitioner has made progress with their substance abuse issues, records submitted with the reauthorization request clearly indicate that Petitioner continues to use substances, so Petitioner is not stable yet in this area. (Exhibit A, pp 28, 34-35.) Finally, records submitted with the reauthorization request indicate that while Petitioner has housing, they need assistance with linking and coordinating to maintain that housing. Petitioner receives CLS to help them maintain the household, which requires coordination, and Petitioner needs coordination with maintenance of the household, as evidence by the fact that Petitioner needed assistance dealing with an infestation and has faced eviction threats in the past due to the condition of the home. (Exhibit A, p 30.) While it does appear that Petitioner has made progress and eventually will be stable without TCM, it does not appear that Petitioner has reached that point yet and that was evident from the reauthorization documentation submitted with Petitioner's request. As such, CMH's decision was improper and should be reversed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH's decision is REVERSED.

Within 10 days of the receipt of this Order, CMH must authorize Petitioner's continued Targeted Case Management.

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

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