[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: April 7, 2021
MOAHR Docket No.: 21-000306
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 March 11, 2021. Petitioner appeared and testified on her own behalf. [redacted], Petitioner's Case Manager at Hope Network, also testified as a witness for Petitioner. Anthony Holston, Vice-President of Grievance and Appeals at Beacon Health Options, represented the Respondent Lakeshore Regional Entity. Kate Ryder, Utilization Reviewer Specialist at Network 180, and Dr. Sidney Cohen, Physician Adviser, testified as witnesses for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-81. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly decide to terminate Petitioner's Targeted Case Management services?

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 [redacted] ([redacted]) year-old Medicaid beneficiary who has been diagnosed with chronic post-traumatic stress disorder and attention-deficit hyperactivity disorder, combined type. (Exhibit A, pages 27, 37).

2. Due to her diagnoses and functional limitations, Petitioner has been authorized for services through Respondent, a Prepaid Inpatient Health

Plan (PIHP), and Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent. (Exhibit A, page 27).

3. In September of 2019, Petitioner was referred for targeted case management services through Network 180. (Exhibit A, page 37).

4. At that time, Petitioner had been without her medications for approximately a month; she was experiencing increased depression and low mood; she had trouble managing her income through social security and finances; she had some legal issues involving driving without a license; and she was homeless and living out of a van. (Exhibit A, page 37).

5. Targeted case management services were then approved in October of 2019. (Exhibit A, pages 32, 37).

6. Goal #1 for Petitioner's targeted case management services was described as follows: "Promote Independence: 'Obtain independent housing, purchase a 'newer vehicle,' maintain current benefits, one day own her own resale shop, and have a home in Florida and Grand Rapids, MI.'" (Exhibit A, page 32).

7. Petitioner consistently engaged in targeted case management over the next thirteen months. (Exhibit A, page 46).

8. She was also able to secure an apartment, though she did not like it; get the court charges against her for driving without a license dropped; and apply for Home Help Services (HHS) through the Department of Health and Human Services (DHHS). (Exhibit A, pages 33-5, 46)

9. She was moderately engaged in therapy and received medications from her primary care physician, but also continued to compulsively shop online. (Exhibit A, page 46)

10. Her Case Manager recommended that targeted case management services be continued to ensure that Petitioner stayed housed and connected to medical resources and DHHS. (Exhibit A, pages 47, 58).

11. She also recommended that Petitioner's therapy and medication management be continued as well. (Exhibit A, page 47).

12. On November 10, 2020, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner no longer met medical necessity for targeted case management services and that the services would be terminated on January 10, 2021. (Exhibit A, pages 28-31).

13. The notice also stated that:

> Writer is recommending a transition to OP therapy, Case Management with Area Agency Aging or Senior Neighbors and/or DHHS chore worker. If unable to connect the client to an outpatient providers [sic], you will be eligible for the stepped down benefit. Please contact your current provider to assist with a transition to the recommended services and supports.

Exhibit A, page 28

14. On January 4, 2021, Petitioner requested an internal appeal with Respondent regarding that decision. (Exhibit A, pages 13-21).

15. On January 21, 2021, Respondent sent Petitioner a Notice of Appeal Denial stating that the decision to terminate Petitioner's targeted case management services was being upheld. (Exhibit A, pages 2-12).

16. With respect to the reason for the decision, the Notice of Appeal Denial stated:

> An appeal reviewer who was not involved in the original decision not to certify care has reviewed the available information. A Beacon Peer Advisor board certified psychiatrist (MD) specializing in behavioral medicine who was not involved in the original decision not to certify care has also reviewed the available information. This review included any additional information received in support of your appeal. Based on the reviewer's understanding of this information, your benefit plan, and Michigan Medicaid Provider Manual, Beacon Health Options has decided that the prior decision not to certify the requested treatment is correct and is therefore, upheld.
>
> You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

Exhibit A, page 3

17. On February 8, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding Respondent's decision. (Exhibit A, pages 63-78).

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 has been receiving targeted case management services through Respondent. With respect to such services, 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, October 1, 2020 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 93-94

Moreover, with respect to the medical necessity referenced in the above policy, 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, July 1, 2020 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 14-15

Here, as discussed above, Respondent decided to terminate Petitioner's targeted case management services pursuant to the above policies.

In support of the action, the Utilization Reviewer Specialist at Network 180 testified that Petitioner's diagnoses and symptoms no longer supported medical necessity for targeted case management services at the time of the decision in this case given the progress Petitioner had made and Petitioner's current status. In particular, she testified that Petitioner had secured housing through a voucher program that could also provide supports to Petitioner; Petitioner was receiving medication management through her primary care physician; she was found to have none-to-minimal symptoms of depression or psychosis; and she was fully alert, oriented, and engaged during a mental status examination. The Utilization Reviewer Specialist further testified that Petitioner has not required any hospitalizations or crisis services since 1966; Petitioner knows how to seek assistance; and that some of the referrals Network 180 made as

part of the transition process can assist Petitioner. She also testified that, if things have changed since Respondent's decision, then Petitioner can always re-request services.

Respondent's Physician Adviser also testified that Petitioner was homeless and not taking care of her needs, including her depression and anxiety, when targeted case management services began, but that Petitioner has made significant progress over the course of a year and now has stable housing, controlled depression, organized thinking, consistent medications, and good insight into her needs. The Physician Advisor further testified as to why Petitioner's progress established that she no longer met medical necessity criteria for targeted case management services.

In response, Petitioner testified that she has no supports from family or friends, and has had to muddle through her life alone, which has worked at times, but that also lead her to being homeless for four years. Petitioner further testified that she no longer understands paperwork or how to get assistance on her own, and that it was only with the help of her Case Manager that she was able to secure housing, food stamps, and home help services. Petitioner further testified regarding her physical health problems and the issues she is having with her landlord over her apartment, with her landlord looking to evict her.

Petitioner's Case Manager testified that she was only recently assigned to Petitioner's case, but that she has already seen a need for targeted case management services given Petitioner's unstable housing, memory issues, difficulties with paperwork, and lack of organizational skills. The Case Manager also testified that she does not believe that the other resources referred by Respondent would be able to assist Petitioner.

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 her burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner was approved for targeted case management services in the past and her Case Manager has recommended that such services be continue, but that alone is not enough to demonstrate medical necessity for the requested services and the remainder of the record establishes that Petitioner did not meet the criteria for targeted case management services at the time of the decision at issue in this case. In particular, it was undisputed that, at the time of the decision at issue in this case, Petitioner had secured housing and other services, including medication management, food stamps and home help services, and had significantly improved her mental state. Moreover, while it is also undisputed that Petitioner secured that housing and other services with the assistance of her Case Manager, such assistance would appear to be no longer needed given Petitioner's progress, greater stability in life, and the other resources

identified by Respondent that would be able to assist Petitioner as she transitioned out of targeted case management services over the course of several months.

Additionally, while neither Petitioner nor her Case Manager believe that the other resources identified by Respondent would be able to assist Petitioner, the record does not reflect that Petitioner even tried to utilize them or why they could not assist her. Petitioner may prefer one resource over another, or be comfortable with her current case management services, but that does not demonstrate medical necessity.

Moreover, while Petitioner and her Case Manager credibly identified issues with Petitioner's housing that have arisen since the decision in this case was made and why Petitioner's housing should no longer be considered stable, those were not the circumstances at the time of Respondent's decision and the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time the decision was made.

To the extent Petitioner's circumstances have changed or she has new or updated information to provide regarding her need for targeted case management services, then she can always request such services again in the future. With respect to the decision at issue in this case however, Respondent's action 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 terminated Petitioner's targeted case management services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS-Location Contact

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