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Date Mailed: September 14, 2021
MOAHR Docket No.: 21-000490
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 18, 2021. [redacted], Petitioner's Sister, appeared and testified on Petitioner's behalf. Petitioner and [redacted] Petitioner's Brother, also testified as witnesses for Petitioner. Anthony Holston, Assistant Vice-President of Grievance and Appeals at Beacon Health Options, represented the Respondent Lakeshore Regional Entity. Kate Ryder, Utilization Reviewer Specialist at Network 180; Dr. Sidney Cohen, Physician Adviser at Beacon Health Options; and Amy Prins-Morofsky, Appeals and Grievance Coordinator at Beacon Health Options; testified as witnesses for Respondent.

During the hearing, Petitioner submitted an evidence packet that was admitted into the record as Exhibit #1, pages 1-238. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-108.

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] year-old Medicaid beneficiary who has been diagnosed with, among other conditions, chronic schizoaffective disorder, bipolar type, and chronic depression. (Exhibit #1, pages 113, 161, 178; Exhibit A, pages 40; Testimony of Petitioner's Representative; Testimony of Physician Advisor).

2. Due to his diagnoses and accompanying 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 40).

3. His services have included bimonthly case management, therapy, and quarterly psych med reviews. (Exhibit #1, pages 114-117)

4. Since at least December of 2013, Petitioner received his approved Individual Therapy, Medication Management and TCM through Cherry Health, a provider contracted with Network 180. (Exhibit #1, pages 114-117; 155-156).

5. In June of 2015, Cherry Health noted that Petitioner works over 15 hours per week at [redacted] and has been there for almost 5 years; he sometimes wants to sleep more than normal; his moods never get out of control; and his last psychiatric hospitalization was years ago. (Exhibit #1, pages 112).

6. On January 9, 2020, Cherry Health noted that Petitioner continues to maintain stability and follow through with treatment recommendations, while also being aware of the need for progress in certain areas. (Exhibit #1, page 155).

7. He did have some hoarding behaviors and mild psychosocial stressors unrelated to occupation or housing. (Exhibit #1, pages 155-156).

8. Cherry Health also found in a Med Management Note on that same day that Petitioner's mood is stable; he continues to work and enjoy it; he lives alone; and he completes his Activities of Daily Living (ADLs) independently. (Exhibit #1, pages 180-187).

9. A goal of his plan at that time was to keep stable. (Exhibit #1, pages 171-179).

10. On April 2, 2020, Cherry Health noted that Petitioner continues to struggle with his hoarding tendencies, but he is continuing to work on it, and he is in the maintenance stage of change overall. (Exhibit #1, pages 151-154)

11. A Med Management Note on that same day stated that Petitioner's mood is stable, with no concerns; he continues to work and enjoy it; and he lives alone and completes his ADLs independently. (Exhibit #1, pages 143-150).

12. On July 29, 2020, Cherry Health noted that Petitioner is functioning well in his maintenance stage; he is still working on keeping his apartment clean; and he is a low risk for suicide/homicide. (Exhibit #1, pages 159-162).

13. A Med Management Note on that same day stated that Petitioner's mood is stable, with no concerns; he continues to work and enjoy it; and he lives alone and completes his ADLs independently. (Exhibit #1, pages 163-170).

14. On September 3, 2020, Cherry Health noted that Petitioner continues to stay busy with work and spending time with his family; he reports struggling with maintaining organizing his appointments and he is in the contemplative stage of change in that area; and he in in the maintenance state of change overall. (Exhibit #1, pages 125-135)

15. On October 9, 2020, Cherry Health noted that Petitioner was experiencing some increased depression with a friend having been unexpectedly killed in a traffic accident. (Exhibit A, pages 85-88) 10/9/20 TCM Note from Cherry Health

16. A Med Management Note on that same day stated that Petitioner has not been feeling well due to a Covid-19 infection and reported increased anxiety related to that infection and missed work, but that his mood is stable, he still lives alone, and he completes his ADLs independently. (Exhibit #1, pages 118-124; Exhibit A, pages 77-84).

17. On November 5, 2020, Cherry Health noted that Petitioner continues to remain stable and manage his affairs independently, and that he is in the maintenance stage of change. (Exhibit A, pages 58-62).

18. In a Biopsychosocial Assessment from Cherry Health completed that same day, it further noted that Petitioner's family and providers are his biggest supports; he maintains mental stability by taking his medications as prescribed and attending appointments as scheduled; he reports some symptoms of depression, but is able to manage them; he lives in an apartment by himself and recently signed a new lease; he maintains his ADLs on his own; he plays and coaches several sports through Special Olympics; he attends church and participates in activities through it; he has a college degree; and he works part time. (Exhibit #1, pages 136-142; Exhibit A, pages 63-76).

19. On December 9, 2020, Cherry Health noted that Petitioner reported doing well and getting back to normal since getting Covid; he was taking his medications and prescribed and had not concerns with symptoms; and that work was going well. (Exhibit A, pages 45-57).

20. That same day, an Individual Plan of Service meeting was held with respect to the plan year from January 1, 2021, to December 31, 2021, with Cherry Health still recommending TCM as part of that plan. (Exhibit #1, pages 103-109; Exhibit A, pages 89-95; Testimony of Utilization Reviewer Specialist).

21. On January 5, 2021, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that his TCM services would be terminated on March 4, 2021. (Exhibit #1, pages 4-8; Exhibit A, pages 41-44).

22. The notice specifically stated that:

> After reviewing documentation, you no longer meet medical necessity for Targeted Case Management and will be offered a 2-month authorization of this service from the date of this notice, expiring on 3/4/2021. The recommended level of care is the Stepped Down Benefit, which is available through your existing provider. This level of care includes outpatient therapy, medication management, and additional ancillary services. Please contact your current provider to assist with a transition to the recommended services and supports.

Exhibit #1, page 4
Exhibit A, page 41

23. With respect to the reason for the adverse benefit determination, the notice stated: "The clinical documentation provided does not establish medical necessity." (Exhibit #1, page 4; Exhibit A, page 13).

24. On January 19, 2021, Petitioner requested an Internal Appeal with Respondent regarding that decision. (Exhibit #1, pages 1-8, 18-27; Exhibit A, pages 2, 30-39).

25. As part of that Internal Appeal, Petitioner's representative argued that Petitioner is eligible for Medicare and Medicare, and therefore automatically qualifies for TCM; he has always been provided the service in the past and his needs have not changed; and TCM is still necessary for Petitioner. (Exhibit #1, pages 18-27; Exhibit A, pages 30-32).

26. On January 29, 2021, Petitioner's representative sent another letter to Respondent disputing the termination of TCM. (Exhibit #1, page 9-27)

27. A Physician Advisor at Beacon Health Options, which has a contractual relationship with Respondent, conducted a review of Petitioner's Internal Appeal. (Exhibit A, pages 96-100; Testimony of Physician Advisor).

28. On February 2, 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 2-10).

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

> You are a [redacted]-year-old male admitted to Targeted Case Management (TCM) services on 12/2/13. You had difficulty caring for your daily needs. You had varying moods and behaviors. You received TCM services, and your symptoms have improved. Your mood is stable. You live by yourself in an apartment. You are able to maintain your home and care for your daily needs. You have a job. You attend community activities. You are engaged in therapy and taking your prescribed medication. You have family support. You cope well with the stressors of everyday life. As of 03/05/21, this level of care will not be medically necessary. The service you requested is not medically necessary. You can be helped with a lower level of care. You can do this with outpatient mental health treatment services.
>
> The following criteria was used in your case, MDHHS Medicaid Provider Manual, 23rd Ed; Behavioral Health and Intellectual/ Developmental Disability-Section 13-Medical Necessity Criteria for TCM. 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
>
> 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, pages 2-3

30. On February 12, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding Respondent's decision. (Exhibit #1, pages 28-30; Exhibit A, pages 101-105).

31. On February 15, 2021, Cherry Health sent Petitioner written notice that it was closing his case because he no longer met clinical eligibility for TCM and psychiatry services. (Exhibit #1, page 45).

32. Petitioner was also advised of his right to request a hearing and to have his services continued. (Exhibit #1, page 45).

33. On February 17, 2021, Petitioner and his representative sent a letter to Cherry Health regarding concerns about Petitioner's mental health records and changes they would like made to it. (Exhibit #1, pages 31-32).

34. In a Discharge Summary dated March 2, 2021, Cherry Health noted that Petitioner appeared to be in the action stage as evidenced by his consistent engagement in services and long-term stability in mental health symptoms. (Exhibit #1, pages 114-117).

35. While Petitioner was discharged from Cherry Health and his services were stopped, they should have been maintained while the hearing in this matter was pending. (Exhibit #1, pages 37-40, 76-78).

36. By the date of the hearing in this matter, *i.e.,* August 18, 2021, Petitioner's TCM had been reinstated. (Testimony of Petitioner's Representative).

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, January 1, 2021 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 94-95

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, January 1, 2021 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 (TCM) services pursuant to the above policies.

In support of the action, the Assistant Manager of Utilization Management at Network 180 testified that TCM is no longer medically necessary given Petitioner's stable housing, income and employment; his natural supports through his family and church; his lack of risk factors; and the fact that he has not utilized any crisis services since starting TCM in 1994. She also testified that Respondent has made alternative services available to Petitioner, including everything he was previously authorized for except TCM. She further testified that neither the fact that Petitioner is eligible for both Medicaid and Medicare nor the fact that he has a chronic mental illness is enough to have TCM approved. She did agree that Cherry Health, the direct provider of Petitioner's TCM and other services, did not recommend termination of Petitioner's TCM.

The Physician Adviser at Beacon Health Options also testified that he reviewed the records provided to him, with a focus on the most recent records, and concluded that TCM is not medically necessary for Petitioner given Petitioner's current functioning status and natural supports. He also testified that, based on those records Petitioner has been getting progressively better over time; he is doing well now; and he does not

have the severity of symptoms that would warrant TCM. He further testified that his decision remains the same even though Petitioner's diagnoses remain the same as Petitioner's level of care needs can change without his diagnoses changing and his symptoms have to put in the context of his functioning. The Physician Adviser did note that Petitioner' services are always subject to ongoing assessments and that, if it becomes necessary, TCM can be requested again in the future and Petitioner will be reassessed.

The Appeals and Grievance Coordinator at Beacon Health Options testified that her job duties include the coordination of documents for the review of the Internal Appeal. She also described those documents for this case,

In response, Petitioner Representative/Sister testified that they are asking to have Petitioner's family's input be considered as there has been inaccurate information in Petitioner's medical records for years, with the record having been changed without his knowledge or approval, and that Respondent is using that wrong information as the basis for its decision, with Petitioner's provider still recommending that Petitioner receive TCM.

Petitioner's Representative also testified Petitioner has always had a Case Manager and that nothing has changed that should lead to a change in Petitioner's services. In particular, she testified that Petitioner still has difficulty caring for his daily needs; he has a high level of vulnerability; and he does not cope well with stress, with Petitioner taking excessive naps to deal with it.

She further testified that Petitioner has chronic mental health conditions, which alone qualifies him for TCM. She also noted that Petitioner still has varying moods and behaviors, and that Respondent cannot just look at a couple good weeks or months when more severe symptoms will inevitably come back.

She also testified that Respondent is improperly punishing Petitioner and discriminating against him for doing things such as living alone, with support; having a job, with support; taking part in community activities; engaging in therapy; taking his medications; and having family supports. She further testified that Petitioner is allowed to do those things, and should be encouraged to do so, not punished.

Additionally, Petitioner's Sister argued that, as Petitioner is eligible for both Medicare and Medicaid, then he is automatically eligible for TCM.

She further testified that events since Respondent's decision have shown Petitioner's need for TCM as there has only been confusion and issues with Petitioner getting TCM while this matter is pending or receiving his other approved services. In particular, she testified that Petitioner has not been able to get documents or appointments scheduled without a Case Manager.

Petitioner's Brother testified that there are inaccuracies in Petitioner's medical records and that, regardless, records do not always capture complete information about a person. He also testified that Petitioner's family knows from their experience in this case that it is a total mess getting TCM reinstated and that the process, which involved months of bureaucracy, is not as fluid as suggested by Respondent. He further testified that they are concerned that, if Petitioner loses the services, then he may never get them back.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in terminating his TCM services. 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 his burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner was approved for targeted case management services in the past and his 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, the record demonstrates that Petitioner has had his symptoms under control for some time; his mental health has both been stable and he continues to be in a maintenance stage, with Petitioner consistent with his medications and therapy; he lives alone and has had long-term stable housing; he has maintained a job for years; and he has natural supports that can assist him as needed. Petitioner is not being punish for his progress, stability or activities, but Respondent must still take them into account and they all support Respondent's decision in this case. Additionally, while it is also undisputed that the above circumstances developed while Petitioner was assisted by a Case Manager over many years, such assistance would appear to be no longer needed given Petitioner's progress, greater stability in life, and natural supports; and, while Petitioner may prefer continuing his case management services, that preference does not demonstrate medical necessity.

Moreover, while Petitioner's Representative argues that Petitioner has a chronic mental health condition and therefore automatically meets the criteria for TCM, that argument is unsupported by any law or policy and must be rejected. The chronic nature of Petitioner's diagnoses is relevant, but that alone does not warrant services and Respondent is required to determine if Petitioner has a medical need for TCM services, with factors including whether he has multiple service needs or a high level of vulnerability, he requires access to a continuum of mental health services from Respondent, and he is unable to independently access and sustain involvement with needed services. Respondent did so in this case and properly found that TCM was no longer needed, with all of the documentation from his provider in the record, from as

earlier as January of 2020, demonstrating Petitioner's stability. Moreover, while Petitioner's Representative asserts that Petitioner's records are inaccurate, and have been for years, the undersigned Administrative Law Judge does not find her testimony to be credible on that issue and, regardless, 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 and that was the information from the provider.

Similarly, to the extent that Petitioner's Representative argues that he automatically meets the criteria for TCM because he is eligible for both Medicaid and Medicare, that argument is unsupported by any law or policy and must be rejected. The specific policy in the MPM outlines the determination of need that must be made in this case, regardless of Petitioner's dual eligibility.

Additionally, while Petitioner's witnesses did credibly identified issues with Petitioner's services that have arisen since the decision in this case was made, with Cherry Health improperly discharging Petitioner, Petitioner was able to get those issues corrected with the help of his natural supports and, regardless, 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 he has new or updated information to provide regarding his need for TCM, then he 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

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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