[redacted]
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Date Mailed: May 14, 2021
MOAHR Docket No.: 21-001166
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 May 11, 2021. [redacted], Case Manager, appeared on behalf of Petitioner. Petitioner also appeared and offered testimony on her own behalf.

Anthony Holston, AVP, Appeals and Grievances appeared on behalf of Respondent, Beacon Health Options (Respondent or Department). Meghan McNeal, Utilization Review Specialist; and Dr. Sydney Cohen, Physician Advisor, appeared as witnesses for the Department.

ISSUE

Did Department 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 Medicaid beneficiary, born [redacted] 1962, who is diagnosed with Bipolar II disorder, Panic disorder, anxiety, and depression. (Exhibit A, p 23; Testimony)

2. Since approximately, December of 2019, Petitioner has been approved for and received TCM through the Department. (Testimony)

3. In approximately August of 2020, Petitioner's ex-husband passed away. The passing caused Petitioner to experience increased anxiety and depression. (Testimony)

4. On November 23, 2020, Petitioner participated in a CRS Psychosocial Evaluation administered by her case manager, [redacted]. The resulting evaluation indicated Petitioner's strengths were the ability to articulate needs, acknowledge psychiatric problems, express desire to change, independent in activities of daily living (ADL), open to learning new behaviors, positive social skills, stable housing and taking medication as prescribed. (Exhibit A, p 117)

5. On or around December 14, 2020, Petitioner participated in a Person Centered Plan of Care. The Plan of Care indicated Petitioner's strengths were independence with ADL's, positive social skills, stable housing and taking medications as prescribed. The Plan of Care requested continued TCM and listed several goals for the 2021 benefit year and further indicated Petitioner as not wanting to develop a "Crisis Plan" at that time. None of the goals listed in the Plan of Care addressed the performance of ADL's. (Exhibit A, pp 124-132)

6. On January 15, 2021, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's TCM benefit would be terminated effective March 15, 2021. The notice stated specifically:

> Per the Michigan Medicaid Provider Manual and 23rd Edition of MCG Criteria, this person no longer appears to meet medical necessity for Targeted Case Management and will be offered a 2 month authorization from the date of review, expiring on 3/15/21. Writer is recommending a transition to the BHH Stepped Down benefit. Please work with your current provider to transition to the BHH Stepped Down benefit. (Exhibit A, p 133)

7. The BHH benefit includes outpatient therapy, medication management, peer support service, clubhouse, supported employment, and group support. (Testimony)

8. On February 4, 2021, the Department received from Petitioner, an Internal Appeal Request. (Exhibit A, p 137)

9. On or around February 22, 2021, Dr. Cohen conducted a review of the appeal and rendered a decision affirming the Department's decision to terminate TCM services. Dr. Cohen concluded the TCM services were not medically necessary as the Petitioner was determined to be motivated and cooperative and able to attend to all basic tasks of everyday life. That Petitioner takes prescribed medications and actively participates in psychotherapy and was less depressed and anxious. Petitioner lived in a stable living environment and had supportive friends and family while attending religious activities. Petitioner's thinking was organized, goal

oriented and she was medically stable. Dr. Cohen opined Petitioner could be treated safely in a less intensive level of care with outpatient mental health treatment services. (Exhibit A, pp 142-144; Testimony)

10. On February 23, 2021, the Department sent Petitioner a Notice of Appeal Denial. The notice indicated Petitioner's request for TCM services was denied. (Exhibit A, p 148)

11. On March 10, 2021, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A, p 146)

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.[1]
>
> 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.[2]

Section 1915(b) of the Social Security Act provides:

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[1] 42 CFR 430.0.
[2] 42 CFR 430.10.

> 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…[3]

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with MDHHS to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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.[4]

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The applicable sections of the Medicaid Provider Manual (MPM) provide:

> **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

[3] 42 USC 1396n(b).
[4] 42 CFR 440.230.

- 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

- <u>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</u>; 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.[5]

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.

[5] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, October 1, 2020, pp 14-15.

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.[6]

The Department witnesses provided testimony indicating Petitioner's conditions have improved, she was stable, meeting her goals, was independent with ADL's, engaged with therapy and religion, taking medications as prescribed, had supportive friends and family, coping with the stressors of everyday life and had a stable living environment. Both Department witnesses testified Petitioner could be treated safely with a lower level of care.

Petitioner's representative argued the Petitioner's conditions had not gotten better and that in fact they were worse. As an example, the Petitioner's representative indicated Petitioner suffered a period of several months where she refused to shower following the death of an ex-husband[7]. Petitioner's representative indicated there were also several notes as well as entries in the psychosocial evaluation that indicated Petitioner's inability to perform basic ADL's and that Petitioner had suicidal ideation.

The notes were not provided, and the psychosocial evaluation was contradictory. And although the Petitioner's Representative indicated the strengths entry in the psychosocial evaluation was an error on her part, they appeared a second time, verbatim, in the Petitioner's most recent Plan of Care. Simply put, the Petitioner's arguments lacked the necessary support needed to meet their burden of proof.

Based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the Department erred in denying Petitioner's request for continued TCM services. TCM services are intended for persons with Serious Mental Illness (SMI) who have multiple service needs and a high degree of vulnerability. The evidence presented does not show the Petitioner as meeting this criterion. As such, the Department's decision was proper and should be affirmed.

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[6] *Id* at 93-94.
[7] August 2020, September 2020, and October 2020.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/dh

Corey Arendt
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	Anthony Holston - 41 Beacon Health Options/ Appeals Coordinator 48561 Alpha Dr Ste 150 Wixom, MI 48393
DHHS Department Rep.	Anthony Holston - 61 Beacon Health Options/ Appeals Coordinator 48561 Alpha Dr Ste 150 Wixom, MI 48393
DHHS -Dept Contact	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913
Authorized Hearing Rep.	[redacted] MI [redacted]
Petitioner	[redacted] MI [redacted]