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Date Mailed: March 27, 2021
MOAHR Docket No.: 21-001473
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 and upon the Appellant's request for a hearing.

After due notice, a hearing was held on May 19, 2021. [REDACTED], Petitioner's Sister-in-law, appeared and testified on behalf of Petitioner. Petitioner and [REDACTED], Petitioner's mother also provided testimony on behalf of Petitioner.

Anthony Holston, AVP, Appeals and Grievances appeared on behalf of Respondent, Beacon Health Options (Department). Dr. Sydney Cohen, M.D., Physician Advisor, and Kristina Lung, Access Coordinator, appeared as witnesses for the Department.

EXHIBITS

Petitioner	1. Misc. Letters
Respondent	A. Hearing Summary

ISSUE

Did Department properly deny Petitioner's request for Supports Coordination 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 a Medicaid beneficiary, born [REDACTED] 1975, who is diagnosed with diabetes, epilepsy, obesity, autism and receives treatment from Dr. VanHaren for anxiety and mental health issues. (Exhibit A, p 30; Testimony.)
2. On November 3, 2020, Petitioner participated in a prescreening

assessment to determine eligibility for services. During the assessment, Petitioner reported to live alone in his own apartment and to be receiving assistance from his 80-year-old mother. It was indicated Petitioner's mother assisted Petitioner with organizing and cleaning his apartment. Petitioner reported to graduating from high school and receiving a bachelor's degree in computer science. Petitioner further indicated that he takes 12 different medications and was able to take them on his own and manage his refills on his own. Petitioner reported that he can perform all Activities of Daily Living (ADL's) on his own without assistance, prompting or reminding. (Exhibit A, p 30; Testimony.)

3. On November 3, 2020, the Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's request for Supports Coordination services were denied as the Petitioner was determined to not meet the Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder. (Exhibit A, pp 22-25; Testimony.)
4. On December 3, 2020, the Department received from Petitioner, a local level appeal. The appeal letter indicated Petitioner was able to manage his own finances and had been living on his own for quite a number of years. (Exhibit A, pp 16-21.)
5. As a result of the local level appeal, the Petitioner's request and file was sent to a physician reviewer for review. Upon completion of review, the physician reviewer determined supports coordination services were not medically necessary as Petitioner did not have any serious emotional or behavioral symptoms which would require the requested services. (Exhibit A, pp 32-33; Testimony.)
6. On December 16, 2020, the Department sent Petitioner a Notice of Appeal Denial. The notice indicated Petitioner's appeal was thoroughly considered and denied. The notice stated specifically:

You are a [] year old [] who requested Support Coordination Services on 11/03/20. You have been diagnosed with Autism Spectrum Disorder, and have a history of anxiety and depression. As of 11/03/20, you had your own apartment, and you drove a car. You were able to cook, do your household chores, and attend to your self-care needs. You did your own shopping, attended to your finances, and you had a supportive family. Your thinking was organized and goal directed, and you were medically stable. On 11/03/20, Supports Coordination Services were not medically necessary. You did not have any serious

emotional or behavioral symptoms which would have required the requested treatment services. (Exhibit A, p 3.)

7. On March 26, 2021, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A, pp 34-38.)

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:

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

¹ 42 CFR 430.0.

² 42 CFR 430.10.

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
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

³ 42 USC 1396n(b).

⁴ 42 CFR 440.230.

- 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.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.

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

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

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	<p>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.</p> <p>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.</p>
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 did not have any serious emotional or behavioral symptoms which would have required the requested treatment services, but that if Petitioner's condition were to deteriorate, Petitioner could re-request services and be reassessed to determine eligibility. At the time of the hearing, Petitioner was able to perform all his own ADL's, was able to drive, take his own medications, cook, and manage his own finances.

Based upon the testimony provided by Petitioner, it appears Petitioner has issues with communication, keeping a job, cleaning, and organizing. These needs alone, do not reflect the requested services as being medically necessary. As such, the Department's decision was proper and should be affirmed.

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 request for supports coordination.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/DH

J. Arendt
Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, Director
Department of Health and Human Services

⁶ *Id* at 93-94.

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

Petitioner

[REDACTED]
[REDACTED]
[REDACTED] MI [REDACTED]

Authorized Hearing Rep.

[REDACTED]
[REDACTED]
[REDACTED] MI [REDACTED]

Authorized Hearing Rep.

[REDACTED]
[REDACTED]
[REDACTED] MI [REDACTED]