GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

[redacted]

Date Mailed: February 15, 2024
MOAHR Docket No.: 23-009324
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on February 7, 2024. [redacted] Petitioner's sister, appeared on behalf of Petitioner. [redacted] Petitioner's mother, appeared as a witness for Petitioner. Pam Fachting, Director of Administrative Servies and Corporate Compliance, appeared on behalf of Respondent, Gratiot Integrated Health Network (Department).

Exhibits:

| | |
|---|---|
| Petitioner | None |
| Department | A – Hearing Summary |

## ISSUE

Did Respondent properly decide to terminate Petitioner's Targeted Case Management (TCM) and Peer Support 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. As of July 2021, Petitioner was residing in the community and receiving services through the Department. (Exhibit A; Testimony).

2. On October 17, 2023, Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated the following:

> You have agreed to end your case management and peer support services acknowledging understanding that these services are no longer medically necessary. You have been approved to participate in the meds only program and are eligible to continue seeing Dr. Rangwani for psychiatric services and medication management.[1]

3. On November 9, 2023, Petitioner filed an internal appeal, appealing the October 17, 2023, notice. (Exhibit A; Testimony).

4. On November 22, 2023, the Department sent Petitioner a Notice of Appeal Denial. The notice indicated the following:

> Case management and peer support services are no longer medically necessary. The presence of a schizophrenia diagnosis alone does not demonstrate medical necessity. There must also be substantial related functional impairments. The biopsychosocial assessment and LOCUS assessment do not demonstrate adequate functional impairments to warrant continuing services. The focus of the services has been simply monitoring Tio's social activities and progress on healthy behaviors. There has been no active linking, assessing, or assisting with benefit entitlements needed in the past year. Peer support services have been solely social and recreational. Tio is able to access the Drop-In Center independently, as well as other social and recreational activities in the community. He is also making progress on healthy behaviors independently. The LOCUS score of 10 does not demonstrate need for case management or peer support service. Clinical Director finds that medication-only services is the only service that is medically necessary at this time.[2]

5. On December 19, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner. (Exhibit A).

## 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:

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[1] Exhibit A, p 79.
[2] Exhibit A, p 92.

> 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.[3]

> 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.[4]

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… [5]

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).

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[3] 42 CFR 430.0.
[4] 42 CFR 430.10.
[5] 42 USC1396n(b).

Eligibility for services through Department is set by Michigan Department of Health and Human Services policy as outlined in the Medicaid Provider Manual (MPM). Specifically, the applicable version of the MPM states in the pertinent part that:

> **1.6 BENEFICIARY ELIGIBILITY**
>
> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

| **In general, MHPs are responsible for outpatient mental health in the following situations:** | **In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:** |
|---|---|
| ▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role | ▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform |

| | |
|---|---|
| performance, etc.) and minimal clinical (self/other harm risk) instability.<br><br>▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports. | daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).<br><br>▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. |

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.[6]

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2023, pp 2-3.

*MPM, July 1, 2019, version*
*Behavioral Health and Intellectual and Developmental Disability Support and Services*
*pages 3-4*

The State of Michigan's Mental Health Code defines serious mental illness and serious emotional disturbance as follows:

> (3) "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
>
> (a) A substance abuse disorder.
> (b) A developmental disorder.
> (c) "V" codes in the diagnostic and statistical manual of mental disorders.
>
> (4) "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> (a) A substance abuse disorder.
> (b) A developmental disorder.

(c) A “V” code in the diagnostic and statistical manual of mental disorders.[7]

Additionally, with respect to developmental disabilities, the Mental Health Code also provides in part:

(27) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

(i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
(ii) Is manifested before the individual is 22 years old.
(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.[8]

Here, as discussed above, Petitioner has been receiving TCM and Peer Support services through Department. 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

[7] MCL 330.1100d.
[8] MCL 330.1100a(25).

> 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.[9]

However, regarding the location of services through Respondent, the MPM also provides in part:

> **2.3 LOCATION OF SERVICE [CHANGES MADE 4/1/21]**
>
> Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be

[9] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2023, p 105.

> provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.
>
> *For beneficiaries residing in nursing facilities, only the following clinic services may be provided:*
>
> - *Nursing facility mental health monitoring;*
> - *Psychiatric evaluation;*
> - *Psychological testing, and other assessments;*
> - *Treatment planning;*
> - *Individual therapy, including behavioral services;*
> - *Crisis intervention; and*
> - *Services provided at enrolled day program sites.*
>
> *Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.*[10]

Here, as discussed above, Department terminated Petitioner's TCM, and Peer Support services pursuant to the above policies. Specifically, the Department indicated Petitioner was no longer eligible for the services as the Petitioner no longer met the beneficiary eligibility criteria as defined in the MPM and corresponding excerpts from the Mental Health Code.

Petitioner did not provide any evidence to rebut the Department's position or show that Petitioner met the eligibility criteria defined above. Consequently, based on the evidence presented, Petitioner has failed to meet his burden of proof and the Department's decision must, therefore, be affirmed.

[10] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2023, p 10.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly terminated Petitioner's TCM and Peer Support services.

**IT IS THEREFORE ORDERED** that:

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

CA/pe

**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

**Via Electronic Mail:**

**DHHS Department Contacts**

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**Authorized Hearing Representative**

[redacted]

**Petitioner**

[redacted]