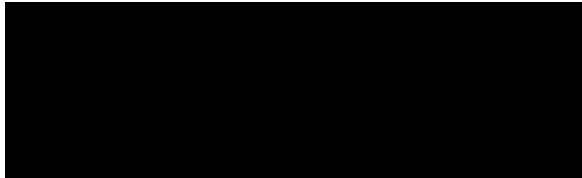




GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON I. BROWN, DPA
DIRECTOR



Date Mailed: April 5, 2024
MOAHR Docket No.: 24-001399
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on March 12, 2024. Petitioner appeared and testified on her own behalf. George Motakis, Compliance Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Kelsey Wright, a Utilization Review Specialist at Network 180, also testified as a witness for Respondent.

During the hearing, the following exhibits were also entered into the record without objection:

- Exhibit #1: Request for Hearing
- Exhibit A: Network 180 Documentation
- Exhibit B: Notice of Receipt of Appeal
- Exhibit C: Notice of Appeal Denial
- Exhibit D: Appeal Summary Report

ISSUE

Did Respondent properly deny Petitioner's request for 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 a twenty-three (23) year-old Medicaid beneficiary who has been diagnosed with post-traumatic stress disorder; borderline personality disorder; an unspecified eating/feeding disorder; and cannabis use disorder. (Exhibit A, pages 1, 4).
2. She also has a history of childhood trauma; disordered eating; residential programming; inpatient hospitalization; and chronic suicidal ideations. (Exhibit A, page 20).
3. In 2020, Petitioner was screened and approved for services through Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP). (Exhibit A, page 2; Testimony of Respondent's representative).
4. At that time, Petitioner reported experiencing severe nightmares; delusions; preoccupation; and chronic suicidal thoughts, with no intent or plan. (Exhibit A, page 2).
5. It was also determined that services would help her transition into adulthood. (Testimony of Utilization Review Specialist).
6. She had not attempted suicide since 2019 or been hospitalized since 2020. (Testimony of Petitioner; Testimony of Utilization Review Specialist).
7. Specific services approved by Network 180 included individual therapy; medication reviews; peer support services; and targeted case management services. (Exhibit A, page 41).
8. With assistance from her Case Manager, Petitioner subsequently secured stable housing. (Testimony of Petitioner; Testimony of Utilization Review Specialist).
9. On August 9, 2023, during a Medication Review, Petitioner reported doing okay, with no symptoms of restlessness, panic, psychosis, mania, or self-harm. (Exhibit A, page 25).
10. On August 23, 2023, Petitioner had a meeting with her Case Manager to assess Petitioner's progress toward her case management goals. (Exhibit A, page 17).

11. During that meeting, the Case Manager noted that she had linked Petitioner to housing resources, but that Petitioner reported being overwhelmed and not exploring them yet. (Exhibit A, pages 17-18).
12. On October 20, 2023, Petitioner had a meeting with her Case Manager to follow up on Petitioner's request for assistance in completing an application for food assistance. (Exhibit A, page 16).
13. During that meeting, the Case Manager confirmed that Petitioner had completed the application on her own and was now approved for food assistance. (Exhibit A, page 16).
14. Petitioner also reported studying for her driver's test, with a plan to take the test in the spring. (Exhibit A, page 16).
15. On September 29, 2023, Petitioner and Network 180 conducted an Individual Plan of Service (IPOS) meeting with respect to Petitioner's services, with Petitioner's current IPOS set to expire on October 1, 2023. (Exhibit A, page 19).
16. As part of the proposed IPOS that was developed, Petitioner identified a goal of moving into a new apartment and taking steps to obtain her driver's license. (Exhibit A, page 21).
17. In support of that goal, Petitioner requested that her targeted case management services be reauthorized for six months. (Exhibit A, pages 21-22).
18. On November 2, 2023, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner's request for targeted case management services had been denied on the basis that she does not meet clinical eligibility criteria for the services. (Exhibit #1, pages 3-6; Exhibit A, pages 32-38).
19. The Notice of Adverse Benefit Determination also stated in part:

You asked for 6 months of Case Management. This was to help you learn a routine that would support your daily needs, including housing, education, transportation and financial resources. As of 11/2/2023, your mental health symptoms have improved. You have safe housing. You have set a stable routine and developed a good support system. You have food security. You do not have case management needs that require this level of care. Outpatient therapy, medication management and peer support is recommended. This is available through

your current provider. Please call your Case manager with questions.

Exhibit #1, page 3
Exhibit A, page 32

20. Network 180 further determined that Petitioner's therapy, medication management, and peer support services would be reauthorized. (Exhibit A, page 41).
21. On December 8, 2023, Petitioner filed an Internal Appeal with Respondent regarding the decision to deny a reauthorization of targeted case management. (Exhibit B, pages 1-5).
22. On December 13, 2023, Respondent sent Petitioner a Notice of Appeal Denial. (Exhibit C, pages 1-6).
23. With respect to the reason for the denial, the notice stated in part:

Your Internal Appeal was denied for the service/item listed above because:

You asked for 6 months of Case Management. This was to help you learn a routine that would support your daily needs, including housing, education, transportation and financial resources. As of 11/2/2023, your mental health symptoms have improved. You have safe housing. You have set a stable routine and developed a good support system. You have food security. You do not have case management needs that require this level of care.

Outpatient therapy, medication management and peer support is recommended. This is available through your current provider. Please call your Case manager with questions.

Exhibit C, page 1

24. In January of 2024, Petitioner was approved for a housing choice voucher through the United State Department of Housing and Urban Development (HUD), though she has not applied for specific housing yet. (Testimony of Petitioner).
25. On February 14, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this

matter regarding targeted case management services. (Exhibit #1, pages 1-6).

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:

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.

Moreover, while targeted case management are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. See 42 CFR 440.230. Regarding medical necessity, 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, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15*

Here, as discussed above, Respondent denied Petitioner's request to reauthorize targeted case management services pursuant to the above policies.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner was previously approved for targeted case management services, but that alone is not enough to demonstrate a continuing need for the services and, as credibly and fully explained by the Utilization Review Specialist at Network 180, targeted case management services were no longer necessary given Petitioner's improvement.

In particular, the Utilization Review Specialist noted that, while Petitioner was approved for targeted case management due to her mental health issues and to assist in her transition into adulthood, Petitioner was now stable at her baseline, with no hospitalizations or suicide attempts in years or self-harm in months; she had secured food assistance on her own; and she had stable housing.

The Utilization Review Specialist also testified that Petitioner's other services, including therapy and peer support services would continue, but that Petitioner did not require the more restrictive targeted case management services at this time, though Petitioner could reapply for them if they became necessary in the future.

In response, Petitioner testified in part that she wants continuing targeted case management to assist her in securing her general equivalency diploma (GED), and a driver's license.

However, while the services could be beneficial in doing so, the undersigned Administrative Law Judge does not find them necessary given Petitioner's improvement, her demonstrated abilities, and other available resources.

Petitioner also testified that, while her current housing is stable, her apartment is bad and she wants targeted case management services to assist her in obtaining Section 8 housing through HUD, with Petitioner recently approved for a housing choice voucher. However, that development arose after the decision at issue in this case and, even considering it, the undersigned Administrative Law Judge again does not find that Petitioner has demonstrated a medical necessity for targeted case management services given the record in this case, Petitioner's improvement, her demonstrated abilities, and other available resources.

To the extent Petitioner's circumstances change or she has additional or updated information to provide regarding her need for targeted case management, then Petitioner can always request such services again in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

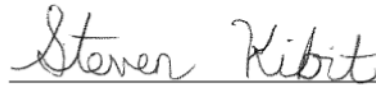
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for targeted case management services.

IT IS THEREFORE ORDERED that:

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

SK/sj


Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 5th day of April 2024.

S. James

S. James

**Michigan Office of Administrative
Hearings and Rules**

Via Electronic Mail:

Community Health Representative
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c/o George Motakis, State Fair Hearing
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Via First Class Mail:

Petitioner

