GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

[redacted]

Date Mailed: November 6, 2024
MOAHR Docket No.: 24-009766
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 October 9, 2024.

Petitioner appeared and testified on her own behalf. Lydia Keith, Petitioner's Case Manager at Pine Rest Christian Mental Health Services ("Pine Rest"), also testified as a witness for Petitioner.

George Motakis, Compliance Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Alyssa Stone, a Utilization Review Specialist at Network 180; and Michelle Anguiano, a Customer Services Manager with Respondent, also testified as witnesses for Respondent.

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

Exhibit A: Notice of Adverse Benefit Determination and Appeal Packet

Exhibit B: Appeal Request and File

Exhibit C: Notice of Receipt of Appeal

Exhibit D: Notice of Appeal Denial

Exhibit E: Appeal Summary Report

Exhibit G: Notice of Hearing

ISSUE

Did Respondent properly deny reauthorization of 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 a fifty-four (54) year-old Medicaid beneficiary who has been diagnosed with major depressive disorder; generalized anxiety disorder; borderline personality disorder; post-traumatic stress disorder; alcohol use disorder, in sustained remission; and marijuana abuse. (Exhibit A, pages 11, 22-23, 31).

2. She also has a history of childhood trauma, including childhood abuse; suicidal attempts and self-injurious behavior; hospitalizations; alcohol abuse; and cannabis abuse. (Exhibit A, pages 23-28).

3. Petitioner was first hospitalized in 2002, and most recently hospitalized in January of 2020. (Exhibit A, page 23).

4. In 2016, Petitioner was approved for services through Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP). (Exhibit A, pages 22, 24; Testimony of Respondent's representative; Testimony of Utilization Review Specialist).

5. As part of her services, Petitioner received targeted case management services at Network 180. (Testimony of Utilization Review Specialist).

6. In May of 2020, Petitioner's targeted case management services through Respondent and Network 180 were transferred to Pine Rest. (Exhibit A, pages 22, 24; Testimony of Utilization Review Specialist; Testimony of Customer Services Manager).

7. At that time, Petitioner reported that her symptoms of anxiety, depression and post-traumatic stress disorder were interfering in her ability to maintain stable relationships and housing. (Exhibit A, page 22).

8. She also identified her goals as growing in her relationship with God, finding housing, and continuing to work on changing her perspective and working on her anxiety and depression. (Exhibit A, pages 22, 30).

9. Petitioner continued to receive other services at Network 180, including outpatient therapy and medication management. (Testimony of Utilization Review Specialist; Testimony of Customer Services Manager).

10. By 2024, and after receiving services, including targeted case management services, for eight years, Petitioner symptoms had stabilized and were manageable with medication and she had maintained an apartment for over a year. (Exhibit A, pages 50, 55; Testimony of Petitioner; Testimony of Case Manager; Testimony of Utilization Review Specialist; Testimony of Customer Services Manager).

11. Her anxiety and stress would increase when dealing with paperwork, and her Case Manager continued to assist her with issues related to a land deed in the State of Texas; her income tax refund being garnished; submitting paperwork to the Department of Health and Human Services (DHHS) for Medicaid; requesting funds from her church; obtaining bus tickets; and locating new housing. (Exhibit A, page 35; Exhibit B, pages 3-78).

12. On May 31, 2024, Petitioner requested another twelve (12) months of targeted case management services through Network 180 and Respondent. (Testimony of Utilization Review Specialist).

13. On June 7, 2024, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner's request for targeted case management services had been partially denied. (Exhibit A, pages 1-10).

14. The Notice of Adverse Benefit Determination also stated in part:

> You asked for twelve (12) months of Targeted Case Management. Your goals were to continue working on helping your mental health symptoms. You have a therapist, and you are taking medications as prescribed. Targeted Case Management is no longer medically necessary. This service will end on 9/07/2024. Your goals can be supported with a lower level of care. You can continue to receive therapy, medication management and your injection. Please contact your current Case Manager with questions.
>
> * * *
>
> The clinical documentation provided does not establish medical necessity.

Exhibit A, page 1

15. On June 20, 2024, Petitioner filed an Internal Appeal with Respondent regarding the decision to deny a reauthorization of targeted case management. (Exhibit B, pages 1-78).

16. In that Internal Appeal, Petitioner wrote that she had used so much case management that she ran out of units; she still needed help with things like housing, resources, calling different people, DHHS, and budgeting; and that she had a voucher, but the apartment she was going to move into recently fell through. (Exhibit B, page 2).

17. On June 27, 2024, Respondent sent Petitioner a Notice of Appeal Denial. (Exhibit D, pages 1-6).

18. 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 requested that your targeted case management services be continued. You have done really well on your medications. There is no indication of any daily needs that require the support of case management services. You have been recommended to continue outpatient and medication management services.

Exhibit D, page 1

19. On August 28, 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 F, pages 1-3).

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.
>
> * * *
>
> **13.2 DETERMINATION OF NEED**
>
> The determination of the need for case management/supports coordination 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/supports coordination is needed or not must be documented in the beneficiary's record. Beneficiaries must be provided choice of available, qualified case management/supports coordination staff upon initial assignment and on an ongoing basis.
>
> *MPM, April 1, 2024 version*
> *Behavioral Health and Intellectual and*

Moreover, while targeted case management services 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 and on the basis that the services were no longer medically necessary.

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 Respondent's witnesses, targeted case management services were no longer necessary given Petitioner's improvement.

In particular, those witnesses noted that Petitioner has been stable at her baseline; there has been no hospitalizations, self-harm or suicide attempts in years; and she has stable housing. Petitioner's other services, including outpatient therapy and medication management, will also continue and provide Petitioner with the supports she needs.

Moreover, while both Petitioner and her Case Manager credibly testified as to how targeted case management has assisted Petitioner in the past, as well as their fears that Petitioner will regress without them; they did not establish that the services are currently needed, as opposed to simply being beneficial; and the undersigned Administrative Law Judge does not find them medically necessary given 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 reauthorization of targeted case management services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

SK/pe

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

Via Electronic Mail:

DHHS Department Contacts

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