STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

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

MARLON BROWN
DIRECTOR

[redacted]

Date Mailed: October 18, 2024
MOAHR Docket No.: 24-010061
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 October 16, 2024. [redacted] Petitioner's public guardian, appeared on Petitioner's behalf. [redacted] Petitioner appeared as a witness.

George Motakis, Fair Hearing Officer, appeared on behalf of Respondent, Lakeshore Regional Entity, the PIHP for Network 180 (Respondent of CMH). Alyssa Stone, Utilization Review Specialist, and Michelle Anguiano, Customer Service Manager, appeared as witnesses for Respondent.

ISSUE

Did Respondent 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 who has been receiving services through Respondent. (Exhibit A; Testimony.)

2. Petitioner is diagnosed with Bipolar disorder, anxiety, polypharmacy, mild intellectual disability, bilateral sciatica, and chronic bilateral low back pain. (Exhibit A, p 32; Testimony.)

3. Petitioner lives semi-independently in an Adult Foster Care (AFC) home at Farragut Home and receives CLS support through the staff there several hours a day. (Exhibit A, p 28; Testimony.)

4. Petitioner has a legal, public guardian. (*Id*.)

5. In June 2024, Petitioner submitted a request for 12 months of continued TCM and, after review, Respondent concluded that Petitioner no longer met the medical necessity criteria for continued TCM because Petitioner had made noted improvements while receiving TCM. (Exhibit A, p 11; Testimony.)

6. Respondent also recommended that a 3-month transition authorization be provided to allow Petitioner to get set up with outpatient therapy and outpatient medication management. (*Id*.)

7. On July 29, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination (NABD) informing Petitioner that her request for 12 months of TCM was partially denied. (Exhibit A, pp 4-10; Testimony) Specifically, the NABD indicated:

> You asked for twelve (12) months of Targeted Case Management. Your goals were to take medications and be happy. You have a therapist, and you are taking medications as prescribed. Targeted Case Management is no longer medically necessary. This service will end on October 29, 2024. Your goals can be supported with a lower level of care. You can continue to receive therapy, medication management, and your injection. (Exhibit A, p 4; Testimony.)

8. On August 2, 2024, Petitioner requested an Internal Appeal. (Exhibit A, pp 1-2; Testimony)

9. On August 22, 2024, after reviewing Petitioner's appeal, Respondent sent Petitioner a Notice of Appeal Denial, which upheld the original findings. (Exhibit C; Testimony). Specifically, the Notice indicated:

> Your appeal was reviewed for targeted case management (TCM). You are doing well. You do not report that you are at risk of abuse or violence. There are no identified risk factors related to abuse/violence, housing, or financial insecurities. You have not reported any daily needs that require TCM. (Exhibit C, p 1; Testimony.)

10. On September 9, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit E)

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.
>
> *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…

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) Medicaid Managed Specialty Services waiver. Respondent contracts with MDHHS to provide specialty mental health services. Services are provided by

Respondent pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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. *See 42 CFR 440.230.* Medical necessity is defined by the Medicaid Provider Manual as follows:

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; 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
April 1, 2024, pp 12-14

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.

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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
April 1, 2024, pp 96-97

Respondent's Utilization Review Specialist (URS) testified that she holds a master's degree in social work, works at Network 180 as a URS, and Petitioner's request for TCM was randomly assigned to her on June 20, 2024. Respondent's URS indicated that she has had no personal contact with Petitioner, which is on purpose, so she can review requests without bias. Respondent's URS testified that she completed the review on July 29, 2024 and looked at all documentation in Petitioner's case file going back to June 2023. Respondent's URS reviewed the requirements for TCM and indicated that in her reviews she is looking for a period of mental health stability for at least one year before TCM will be discontinued.

Respondent's URS testified that Petitioner has been using TCM since 2018 but was identified as an under utilizer of those services over the past year. Respondent's URS noted that when considering underutilization of TCM services during the past year, she did consider the fact that Petitioner was in sub-acute rehabilitation for three months. Respondent's URS reviewed medical necessity criteria and determined that TCM was no longer medically necessary for Petitioner. Respondent's URS indicated that Petitioner has had no mental health crisis since 2020, that she has stable housing with built in supports (an AFC home) and can obtain the ongoing services she needs through outpatient therapy and outpatient medication management through her Medicaid health insurance. Respondent's URS testified that Petitioner has shown improvement with the goals in her IPOS and has met many of the goals. Respondent's URS noted that if circumstances change, or Petitioner deteriorates without TCM, a new review can be conducted.

Respondent's Customer Service Manager (CSM) testified that she also holds a master's degree in social work and she was assigned to complete Petitioner's appeal review. Respondent's CSM indicated that after a review of Petitioner's record, she agreed that Petitioner no longer met the medical necessity criteria for TCM. Respondent's CSM noted that Petitioner has been implementing the skills that she needs and she should be successful at a lower level of care.

Petitioner testified that the only reason she has not been hospitalized more often was because of TCM and without TCM she will be back into the hospital. Petitioner's guardian argued generally that the CMH was not taking into account the chance that Petitioner would regress without TCM or how she would get along without TCM after having the service for so many years.

Based on the evidence presented, Respondent properly denied Petitioner's request for continued TCM services at the time the decision was made. As indicated, TCM is intended for adults with serious mental illness 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. Here, the evidence available to Respondent at the time the decision was made showed that Petitioner had not been hospitalized since 2020, has stable housing (an AFC home with built in supports), has made progress with her goals, and can continue her therapy and medication management on an outpatient basis through her Medicaid health insurance. As such, Petitioner did not show a need for TCM at the time the decision was made because she had improved and stabilized to a point where she did not meet the above medical necessity criteria for someone to receive TCM.

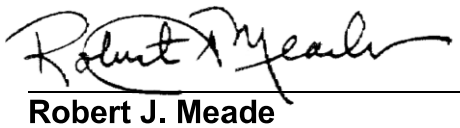
Petitioner's main argument against the denial of continued TCM is that Petitioner may deteriorate without that intense level of service. However, Medicaid can only pay for services that are medically necessary, and here, as indicated above, the services are no longer medically necessary. Should Petitioner's condition deteriorate, she can always ask for a new review.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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



RM/sj

Robert J. Meade
Administrative Law Judge

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

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 18th day of October 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

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