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3. ██████████ is a contractor of the CMH.
4. The Appellant resides in the community in his own apartment. He drives and owns an automobile, receives FAP, Medicaid and Medicare. He has SSI benefits. He has a payee. He attends group therapy.
5. The Appellant attends medication management appointments quarterly or as needed.
6. The Appellant has received case management services through ██████████ in the past.
7. The Department has proposed termination of case management services to the Appellant. There is no proposed reduction to any other services authorized to the Appellant.
8. The Appellant contests termination of his case management services, citing a need for case management to contact his payee if and when necessary.
9. The Appellant states his rent was not paid by the Payee in September and he requires a case manager to contact the payee to determine the reason why and to straighten it out.
10. The Appellant requested a hearing ██████████ to contest the proposed termination of case management services. ██████████.

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

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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 Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [REDACTED] contracts with the Michigan Department of Community Health to provide services under the HSW.

The Appellant is entitled to Medicaid funded services through CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH/CMHSP Managed Specialty Supports and Services Contact: Attachment 3.3.1 and/or 3.3.2.
2. The service in issue is a Medicaid covered service, i.e. State Medicaid Plan or waiver program service, and
3. The service is medically necessary.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. 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*. Case management is a Medicaid covered service. (See Medicaid Provider Manual, Mental Health and Substance Abuse Section, Section 13) The issue in this case is whether continued authorization of case management services is medically necessary for Appellant.

The Medicaid Provider Manual defines terms in the Mental Health/Substance Abuse section dated July 1, 2009. It defines medical necessity as follows:

Determination that a specific services I medically (clinically) appropriate, necessary to meet needs, consistent wit the person’s diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

Medicaid Provider Manual
Mental Health /Substance Abuse
Version date July 1, 2009, page 5.

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 may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

In this case the Appellant contests the proposed termination of case management services. The Department's agent determined they are not medically necessary after a utilization review. The uncontested testimony details the functional and stable status of the Appellant,

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despite his unpaid ██████████ rent. The Appellant does not have transportation barriers. He can access the community for health care, food, medical appointments and does so regularly. He has good grooming, personal hygiene and self care. He is compliant with medication and attends medication review appointments as well as group therapy.

The Appellant contested the proposed termination by stating he is unable to contact his payee directly so requires case management services to determine the reason his ██████████ rent had not been paid. Additionally, he asserts he is in the community without family supports. Furthermore, mental illness is unpredictable and it cannot be known what his future needs will be or when they could arise.

This ALJ finds the Department provided sufficient credible evidence that Appellant has no need for case management services. While the Appellant's concerns about ██████████ rent are real and need to be addressed, case management is not the only avenue to address this issue. There was uncontested evidence from the Department the Appellant is able to access contact with his payee where he goes for medication management services. Additionally, he was authorized for 30 additional days of case management services prior to termination. His concern regarding lack of Community Supports was read by this ALJ, however, case management services are for the purpose of linking to services, not direct support. The Appellant has been linked to medically necessary services such as FAP, Medicaid, Medicare and SSI. He has the ability to access supports available in the community, such as interest and therapy groups, recreational opportunities and worship without case management services. No showing was made that continued case management services would somehow result in increased access to community supports and participation. The Appellant did not establish case management services are medically necessary for him at this time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's action in proposing termination of case management services was proper.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

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CC: [REDACTED]

Date Mailed: 10/15/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.