STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF

Docket No. 2010-10022 CMH
Case No. 11747282

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted] represented himself.

[redacted] (hereinafter CMH or Department) represented the Department of Community Health's agent. [redacted] was present on behalf of the CMH.

ISSUE

Did the CMH properly terminate Case Management Services for the Appellant?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary diagnosed with a serious mental illness.

2. [redacted] is a pre-paid Inpatient Health Plan (PIHP) and contractor of the Michigan Department of Community Health (MDCH).

3. The Appellant has been receiving services through the CMH in his county of residence.

4. The Appellant resides in the community in his own apartment. He is managing both physical and mental health issues. He receives both Medicare and Medicaid benefits after meeting his Medicaid co-payment (formerly spend down).

5. The Appellant's most recent IPOS, in [redacted] authorized eight (8) units of case management services per month. No other services were authorized.

6. The Appellant's case management services were delivered in home and consisted of supportive talk therapy.

7. Following an internal case and utilization management review, CMH proposed termination of case management services to the Appellant.

8. The case review consisted, in part, of a review of his records and LOCUS scoring. He received a score of 11, thus falling below the qualification threshold of 13.

9. The Appellant contests termination of his case management services, asserting a need for services.

10. The Appellant is Medicare eligible.

11. The Appellant requested a hearing [redacted] 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*

> 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.
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> **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.
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> 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.
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> **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.
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> Medicaid Provider Manual
> Mental Health/Substance Abuse
> Version Date: July 1, 2009 Pages 67-68
> Michigan Department of Community Health

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, as well as establishes he is not utilizing his Medicare benefits to access services he may believe he needs. Additionally, the uncontested testimony establishes he was getting supportive "talk therapy" in the form of a listening ear rather than actual case management

services. No evidence was offered that the services provided were consistent with the purposes of targeted case management services as stated above. There was no evidence of helping to establish connections to other community services, including Medicare providers, referrals, or other coordination activity. There was no evidence the Appellant requires training activities or cannot organize his day without support services. The screening tool used (LOCUS) resulted in a score of 11, falling below the qualification threshold of at least 13. Finally, his IPOS does not identify goals that are being addressed by the one (1) visit per month case management that he was participating in. In short, the uncontested testimony established that he was actually engaged in talk therapy delivered 1 time per month in his home, not case management services.

The Appellant contested the proposed termination by stating he needs services and therapy to continue. He is lonely and needs someone to talk to. He asserted he is a human being and not just a number, in reference to his locus score. He said he was advised how to handle certain situations that caused him stress. He stated, when asked, he had never tried to access therapy services through a Medicare provider.

This ALJ finds the Department provided sufficient credible evidence that Appellant has no need for case management services. While the Appellant's concerns about needing to continue therapy one (1) time per month were considered and are important to his sustaining his mental health, this level of need does not evidence qualification for continued services through CMH at this time. He does have access to mental health benefits through Medicare. He may continue to address his stated needs through use of his Medicare benefits. 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 independence or otherwise address the stated goals in his IPOS.

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.

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

cc: [redacted]

Date Mailed: 2/23/2010

***** 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.