STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],
Appellant

_____/

Docket No. 2010-35200 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], from [redacted], appeared on behalf of the Appellant. [redacted], was also in attendance and provided testimony.

[redacted], represented the CMH. [redacted] appeared as a witness for the Department.

ISSUE

Did CMH properly propose termination of Appellant's case management services (CMS) services and transition to home based 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. The Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant is enrolled in [redacted].

3. CMH contracts with [redacted] to provide CMS-supports coordination services to CMH beneficiaries.

4. Appellant's primary diagnosis is bipolar disorder, NOS. (Exhibit D).

5. Appellant's first child and second child were removed by child protective services (CPS). (Exhibit D). Appellant has a baby who currently lives with her. (Exhibit E.)

6. Appellant was receiving CMS services from at least [redacted] as authorized in her yearly Person-Centered Plans (PCP). (Exhibit D). Appellant's [redacted] PCP authorized 2 hours of CMS per month. (testimony).

7. On [redacted], Appellant's [redacted] CMS manager sent to CMH a request for authorization for Appellant's [redacted] PCP, including TCM. (Exhibit E). The request for authorization included a letter of medical necessity which indicated that in the previous year Appellant was not complying with medication management, was arrested, incarcerated and was currently on probation, had a baby which CPS had not yet removed, and had lost her housing. (Attachment E).

8. CMH reviewed the request for authorization and concluded that Appellant's current level of CMS services was not intensive to assist her to remain stable and that home based services (HBS) which could address the needs of both Appellant and her infant were more appropriate. (Exhibit A).

9. As a result of CMH's decision that Appellant needed more intensive services, the CMH determined she no longer met medical necessity criteria for CMS and her CMS could be terminated and she could be transitioned to HBS. (Exhibit B).

10. On [redacted], the CMH[redacted] sent an Advance Action Notice to the Appellant indicating that her CMS would be terminated and she would be transitioned to home based services, effective [redacted]. (Exhibit B).

11. The Appellant's request for hearing was received on [redacted]. (Exhibit C).

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 HBS 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 (HBS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

The CMH representative and witness explained that CMH reviewed Appellant's request for authorization and noted that in the previous year Appellant was not complying with medication management, was arrested, incarcerated and was currently on probation, had a baby which CPS had not yet removed, and had lost her housing. (Attachment E).

The CMH Utilization Manager witness testified that after reviewing the instability in most major life aspects, including lack of medication compliance, CMH concluded that Appellant's current level of CMS services was not intensive enough to assist her to remain stable.

As a result of CMH's decision that Appellant needed more intensive services, the CMH determined she no longer met medical necessity criteria for CMS and her CMS could be terminated and she could be transitioned to HBS. (Exhibit B).

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

> **2.5.B. MEDICAL NECESSITY 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.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, April 1, 2010, page 13.*

The evidence in this case demonstrates that the CMH properly applied medical necessity criteria when making CMS service denial and HBS authorization.

The Appellant's representative argued that the two hours of CSM CMH had authorized prior to [redacted] were not adequate to address the multitude of Appellant's needs. The Appellant's representative asserted that CSM was the appropriate service for Appellant but it needed to be provided more frequently than two hours per month to be effective.

The Appellant admitted she needed services. The Appellant testified that she had trust issues and did not want anyone but her representative to provide CSM services.

The CMH witness responded that the Appellant's needs, including the welfare of her infant, were outside the scope of purpose for CMS. The CMH witness explained that the Appellant was in need of more intensive family focused services than CMS. The CMH witness added

that home based services which could address the needs of both Appellant and her infant were therefore more appropriate. (Exhibits A and F).

The CMH representative and witness supported the CMH position by showing that Targeted Case Management (TCM) is defined in the Medicaid Provider Manual and is intended for assisting beneficiaries to obtain services. The Medicaid Provider Manual defines TCM as:

> **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.
>
> *Medicaid Provider Manual, Mental Health/Substance Abuse, April 1, 2010, Page 67.* (Department Exhibit 1, Exhibit G).

The HBS and TCM policy proffered by CMH demonstrate that CMH properly denied authorization of continued TCM and proposed transition to HBS.

The Appellant must prove by a preponderance of evidence that the CMH denial of CMS services and transition to home based services was improper, but she did not meet the burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

> The CMH's termination of Appellant's case management services transition to home based services was proper.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
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cc: [redacted]

Date Mailed: 8/5/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.