STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

[redacted],
Appellant

_______________________/

Docket No. 2010-6450 CMH

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]. The Appellant appeared without representation. She was accompanied by [redacted], case manager, a potential witness. [redacted], attorney, represented the Department. His witness was [redacted], utilization management coordinator. Also in attendance [redacted], customer service coordinator.

ISSUE

Did the Department properly propose termination of 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 [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is enrolled in a Medicaid Health Plan (MHP), [redacted]. (Appellant's Exhibit #1)

3. The Appellant is afflicted with Schizophrenia, Paranoid Type. (Department's Exhibit A, p. 9)

4. On utilization review the Appellant is considered "stable". She has not suffered a psychiatric hospitalization since (Department's Exhibit A, pp. 6, 7, 9)

5. Appellant has been receiving Targeted Case Management (TCM) from the CMH since . Prior to that she received ACT team services during the years of 004. (Department's Exhibit A, pp. 3, 6).

6. On , the Department advised the Appellant, by Action Notice, that her case management services would be terminated effective , because she no longer met medical necessity criteria.

7. The Department's action notice also included her further appeal rights. (Department's Exhibit B, p. 2)

8. The instant request for hearing was received by SOAHR on . (Appellant's Exhibit #1)

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 waiver. Substance Abuse Services 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.

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

As a person afflicted with a serious mental illness (Schizophrenia, paranoid type) the Appellant is entitled to receive services from the CMH. *See* Medicaid Provider Manual, (MPM) Mental Health [ ], Beneficiary Eligibility, §1.6, April 1, 2010, page 3 and MCL 330.1100d(3)

However, the construction of those services and supports are not static, but rather subject to review by mental health professionals confirming that a current functional impairment and a current medical necessity exists for those specialized services and supports:

[ ] MEDICAL NECESSITY CRITERIA

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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.

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Using criteria for medical necessity, a PHIP may:

- 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.

MPM, Mental Health [ ], Medical Necessity, §§2.5 A, D, pages 12 – 14

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[ ] 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.

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MPM, *Supra*, p. 67

The Appellant testified that she was attached to case managers ” and that she trusted them and would miss them if case management was terminated. She reiterated that she cannot take cabs everywhere.

Her witness emphasized that even on the option of using the Metro – the Appellant suffers anxiety and becomes nervous and desirous of getting home right away.

The Department witness testified that the Appellant has achieved her goals within the last year and has had no hospitalizations and has successfully maintained herself in the community for more than 6 years. She said that this level of achievement was incongruent with the goals of case management and that the Appellant's needs could now be satisfied with supports coordination since her reliance on case management for transportation is neither a case management function nor medically necessary.

On rebuttal the Appellant testified that she never said she wouldn't take mass transportation.

On review, it is clear that the Department did not arbitrarily terminate TCM services, but rather properly decreased the Appellant's services to supports coordination, a lesser but adequate service level, reasonably expected to meet the Appellant's present needs. This level of service was properly reached, in large part, owing to the Appellant's

success in managing her affliction over the years and meeting her goals and objectives as described in her person centered planning.

At hearing the Department volunteered to assure adequate medication management during transition to supports coordination.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly terminated the Appellant's Targeted Case Management for lack of medical necessity.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 5/11/2010

***** 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.