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

,

Appellant
______________________/

Docket No. 2010-7829 CMH
Case No.

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 . was present and represented herself at hearing.

for (CMH), was present on behalf of the Department of Community Health. for the CMH was present as a witness on behalf of the Department. , was present as a Department witness. , was present on behalf of the Department, was present on behalf of the Department, was present and , was present on behalf of the Department.

ISSUE I

Did CMH properly terminate authorization for case management services for the Appellant?

ISSUE II

Did CMH properly deny the Appellant's request for Community Living Services (CLS) 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 Medicaid beneficiary who has been diagnosed with a serious mental illness. (uncontested)

2. The Appellant participates in Community Mental Health services.

3. The Appellant resides in her own home, which is well maintained and very clean. (uncontested)

4. The Appellant lives with her child, a toddler, and the father of her child. (uncontested)

5. The State of Michigan Child Protective Services division has conducted at least one investigation into the Appellant's fitness for motherhood. No neglect or abuse has been substantiated as a result of the State of Michigan investigation. (uncontested testimony of the Appellant)

6. The Appellant is not functionally physically limited in any way evidenced in the record. (uncontested)

7. The Appellant is approved for SSI and food stamp benefits. (uncontested)

8. The Appellant is able to and does drive an automobile, which she owns. (uncontested)

9. The Appellant has pursued the seller of the automobile in small claims court for claims concerning the automobile. (uncontested)

10. The Appellant has access to and knows how to access medical services. (uncontested)

11. The Appellant has access to and knows how to use services and programs offered by the Department of Human Services. (uncontested)

12. The Appellant has been receiving services from CMH since (uncontested)

13. The Appellant is diagnosed on Axis I with schizoaffective disorder. Her Axis II diagnosis includes anti-social personality disorder. Currently it is being determined if she is mildly mentally retarded or has borderline intellectual functioning. (uncontested)

14. The Appellant was authorized, through the CMH, for targeted case management services, in conjunction with medication review services. (uncontested)

15. The CMH proposed to terminate her targeted case management services in . She was offered short term supports coordination through , for a specific goal identified by the Appellant. Her medication management services are continuing. (uncontested)

16. Following notice of termination, the Appellant requested Community Living Supports Services (CLS). (uncontested)

17. The CMH denied the Appellant's request for CLS services. (uncontested)

18. The Appellant contests the termination of targeted case management services as well as the denial of CLS. She forwarded two hearing requests. The two separate requests were merged and one hearing held to make disposition of each dispute.

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. 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.*

The CMH notified the Appellant her targeted case management services would be terminated. She thereafter requested CLS services and was denied. She was advised neither targeted case management services nor CLS were medically necessary. The Appellant objects to the termination and denial of services. She is entitled to Medicaid funded services through CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH Medicaid Provider Manual guidelines.

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.

Case management is a Medicaid covered service if medically necessary. One 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.

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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.

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SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)
PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services,

through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation

The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).

Independence
"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity
Engaged in activities that result in or lead to maintenance of or increased self sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES
The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and

- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES
The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.3.B. COMMUNITY LIVING SUPPORTS
Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments

- acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

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The Department witnesses presented evidence of the Appellant's functional status when citing a lack of medical necessity for targeted case management services and denial of CLS services. The Department witnesses assert she is able to both identify and obtain her goals, as evidenced by her purchase of an automobile and pursuit of the dealer in court. It was further evidenced that she had one short term goal identified, which was addressed by the short term services authorized through [redacted]. The short term goal was finding an in home tutor to address enhanced literacy goals. It was determined that no in home tutor service is currently available in the area, although it was possible to access the service out of the home. Furthermore, she has sought and obtained SSI and food stamp benefits. She does not need assistance getting to shopping, medical or other community services or activities according to the CMH, she otherwise has no identified goals that require authorization of targeted case management services.

The Appellant presented testimony at hearing that she actually obtained her assistance with the aid of her case manager upon her parole from prison. She said it was "untrue" for the CMH to assert she took care of everything on her own. She said she does have SSI Benefits and food stamps, however, between her parole officer and case manager, she had her SSI reinstated and qualified for food stamps. She further stated she does take impeccable care of her son. She provided uncontested testimony she had been reported to Child Protective Services at least one time, been investigated and had not been cited for neglect or abuse.

With respect to the automobile, she said she had been taken advantage of by the dealership so she took them to small claims court. She is still pursuing the issue, following a default entry that was apparently set aside.

The Appellant did not dispute the evidence presented that her home was very clean, except to say sometimes she believes she needs help with chores such as housekeeping, due to her mental illness. She stated she is unable to count money that well and requires assistance at the store. She also needs assistance in the form of prompting to take her medication because she does not want to take it all the time, as well as assistance with laundry sometimes. She said she has an 8th grade education and no work history.

In this case the CMH provided evidence the Appellant does not require case management services. The uncontested evidence includes the fact that the Appellant resides with the father of her child, thus has natural supports. She lives in her own home and operates a vehicle, thus has no need for services connecting her to other resources due to current crises. She has medical coverage in the form of Medicaid and knows how to access providers.

The Appellant functions independently in making her daily decisions, ordering her day and performing ADL's and IADL's. She is not exhibiting signs or symptoms of a serious mental illness that interferes with her day to day functioning. She is able to identify her priorities, express them and take action to accomplish them, according to the evidence of record.

The CMH also sent Notice that the request for CLS services was denied due to lack of medical necessity. The evidence of record unequivocally establishes the Appellant has the mental and physical ability to perform all of her own activities of daily living and instrumental activities of daily living. She requires neither training nor physical assistance in performing the tasks of housework or laundry. She is able to and does take her medication. She has had no hospitalizations since her release from prison in [redacted], thus is exhibiting stability in her functional status. She is taking her medication sufficiently regularly to maintain her functional status and take care of her son and home. She still has authorization for medication management services at this time.

[redacted] provided credible evidence that there is no medically necessary need for targeted case management services or CLS services for the Appellant. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that she met the Medicaid Provider Manual eligibility requirements for either service at this time.

DECISION AND ORDER

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

> The Appellant does not meet the Medicaid Provider Manual eligibility requirements for targeted case management or community living supports services provided through the CMH.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

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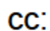
Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health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Date Mailed 2/10/2010

***** 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.