STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2012-43105 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] appeared on Appellant's behalf. Appellant and [redacted], testified as witnesses on Appellant's behalf. [redacted] represented the Kalamazoo County Community Mental Health & Substance Abuse Services ("KCMHSAS"). [redacted] Utilization Management Coordinator, appeared as a witness on behalf of KCMHSAS. [redacted] from KCMHSAS were also present during the hearing, but they did not testify.

ISSUE

Did the KCMHSAS properly decide to terminate Appellant's targeted case management 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. Appellant is a [redacted] who has been diagnosed with schizophrenia paranoid type (stable), panic attacks, and a history of hypertension. [redacted]

2. The KCMHSAS is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant has been receiving services through the KCMHSAS, including targeted case management and a payee/conservator. Appellant also has a Home Help chore provider. [redacted]

[redacted]

4. On [redacted], KCMHSAS reviewed Appellant's services and decided to terminate his targeted case management services. [redacted]

5. Appellant filed a local appeal with respect to the decision to terminate. On [redacted], KCMHSAS sent Appellant notice that it was denying his local appeal and upholding the termination of targeted case management services. The effective date of the termination was to be [redacted]

6. The Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing on [redacted]

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…
>
> (42 USC 1396n(b))

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section articulates the relevant policy and, with respect to targeted case management, it states:

> **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 shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

13.4 STAFF QUALIFICATIONS

A primary case manager must be a qualified mental health or mental retardation professional (QMHP or QMRP); or if the case manager has only a bachelor's degree but without the specialized training or experience they must be supervised by a QMHP or QMRP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QMRP.

(MPM, Mental Health and Substance Abuse Section,
January 1, 2012, pages 69-71)

However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

With respect to medical necessity, the MPM provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> 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.
>
> **2.5.B. 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.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP 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 and Substance Abuse Section, January 1, 2012, pages 12-14)

Here, KCMHSAS decided to terminate Appellant's targeted case management because it found that the service was no longer medically necessary. In support of that finding, KCMHSAS staff noted that Appellant has been stable with respect to both his medication and his behavior for some time. Appellant has been on the same medication since he started with KCMHSAS in 2005 and he has not had any psychiatric episodes in over a year.

[redacted], the Utilization Management Coordinator who reviewed Appellant's services, testified regarding Appellant's stability and the presence of other supports for Appellant. The records relied upon by Hall indicate that Appellant is involved with his church and a fraternity. Hall also testified/wrote that Appellant has a chore provider he is close to and that there have been attempts to steer Appellant toward peer-support services. [redacted]

Similarly, in the notice denying the local appeal, [redacted] also wrote Appellant was doing better and no longer needed intervention from a case manager. [redacted] further noted that KCMHSAS was recommending that Appellant connect with Recovery Institute, which offers peer-run and peer-delivered services and supports. [redacted]

In response, Appellant argues that the stability identified by Respondent has only come about because of the services Appellant has been receiving, including targeted case management. According to Appellant, if that targeted case management is terminated, then Appellant will lose that stability and succumb to his paranoia and delusions. In addition to his own testimony, Appellant also points to the opinions of his case manager [redacted] and treating psychiatrist [redacted] that his targeted case management should continue.

As testified to by both Appellant and his case manager, the primary assistance the case manager provides is simply being there for Appellant and helping him through his day. Appellant will leave up to ten messages on the case manager's work number during the night and, according to Appellant, it simply helps to know that someone is listening. Appellant and his case manager also talk on the phone frequently and they meet once a week for thirty-forty minutes.

With respect to specific incidences of aid, Appellant notes that his case manager assisted him at least two times recently. Once was in [redacted], when Appellant lost his medication and started to panic. His case manager was able to calm him down and advise him what to do. [redacted] Another incident was in [redacted] of [redacted] when Appellant accidently took a double dosage of medication. Again, he called his case manager and his case manager was able to suggest how Appellant should handle his medication in the future [redacted] As seen by Appellant, those two instances of assistance, along with the general assistance the case manager provides, demonstrate why the targeted case management is medically necessary.

Appellant further argues that there is no one else to provide him with the assistance given by his case manager. Both he and his case manager testified regarding a failed attempt at introducing him to a peer support group and his little support from his family.

Appellant bears the burden of proving by a preponderance of the evidence that the KCMHSAS erred in deciding to terminate his targeted case management. Here, this Administrative Law Judge finds that Appellant failed to meet that burden.

While it is clear that Appellant has benefitted from having a case manager in the past, it is not clear that such targeted case management is still medically necessary. Appellant has achieved a certain level of stability in behavior and his medications have not changed since he started with the KCMHSAS in the year 2005. Moreover, while Appellant has demonstrated difficulty in forming new relationships, he appears to have a number of other supports that could replace the assistance provided by his case manager. As testified to by both Appellant and his case manager, the primary assistance the case manager provides is simply being there to respond to messages and provide emotional support/reassurance. As suggested by the KCMHSAS, there is no reason such support/reassurance cannot be provided by other supports, such as his church, fraternity, or a peer-support group.

Similarly, the other two specific examples of case management identified by Appellant could also have been managed by other actors or supports. Lost medications or taking a double dose of medications are not uncommon occurrences and do not expressly require the aid of a case manager.

Appellant has clearly reached a high comfort level with his case manager, but comfort in working with someone specific does not equal medical necessity. Moreover, given enough time and effort, he should be able to reach the same level of comfort with other supports. There is no suggestion that Appellant's relationship with his case manager was as comfortable at the beginning as it is now.

Accordingly, given Appellant's stability and the availability of other sources to meet Appellant's current needs, Appellant has failed to demonstrate by a preponderance of the evidence that the KCMHSAS erred in deciding to terminate his targeted case management. The KCMHSAS' decision is therefore affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the KCMHSAS properly decided to terminate Appellant's targeted case management services.

IT IS THEREFORE ORDERED that:

The KCMHSAS' decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6-27-2012

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.