

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 2014-22553 CMH

██████████

██████████

██████████

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.*, and upon a request for a hearing filed by Appellant.

After due notice, a hearing was held on ██████████, Case Manager at ██████████, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf. ██████████, Fair Hearings Officer, appeared on behalf of Respondent ██████████ (CMH). ██████████, Utilization Management, also testified for the CMH.

ISSUE

Did the CMH 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 █ year-old Medicaid beneficiary who has been diagnosed with mild mental retardation and receiving █ hours per month of targeted case management services through the CMH. (Respondent's Exhibit A, pages 9-11; Testimony of Appellant's representative; Testimony of ██████████).
2. One of the goals in having targeted case management services through the CMH was to help Appellant gain knowledge of maintaining entitlements, amenities, and benefits. (Respondent's Exhibit A, page 23).
3. While having targeted case management services during the past year, Appellant also obtained Social Security benefits, the use of a payee, and additional Medicaid benefits. (Respondent's Exhibit B, page 4)

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4. Appellant has also completed individual therapy with a therapist and reduced her levels of anger and stress. (Respondent's Exhibit B, page 1).
5. Appellant further secured a subsidized apartment and assisted her case manager in maintaining and utilizing her Medicaid benefits. (Respondent's Exhibit B, page 2).
6. In particular, Appellant learned how to arrange transportation to medical appointments through Medicaid. (Respondent's Exhibit A, page 21).
7. Appellant also reduced her Level of Care Utilization System (LOCUS) score during the past year. (Respondent's Exhibit A, pages 10, 12-13).
8. Her LOCUS score of █ on ██████████ was reduced to █ as of ██████████. (Respondent's Exhibit A, pages 10, 12-13).
9. As part of the development of her new plan of services for the upcoming year, Appellant requested that her targeted case management services be reauthorized. (Respondent's Exhibit A, pages 9-10).
10. On ██████████, the CMH sent Appellant written notice that the request for targeted case management was approved in part and denied in part. (Respondent's Exhibit A, pages 6-8).
11. Specifically, while Appellant was approved for targeted case management, the approval was only for █ of the █ units she requested and █ out of the █ months she requested. (Respondent's Exhibit A, pages 6-8).
12. Therefore, she was only authorized to receive █ hours of targeted case management for █ more months and the services would then be terminated. (Respondent's Exhibit A, pages 6-8).
13. On ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing in this matter. (Petitioner's Exhibit 1, pages 1-2; Respondent's Exhibit A, pages 14-15).
14. In that request, Appellant and her representative stated that, due to Appellant's developmental disability; unstable natural supports and lack of transportation, she needed the services in order to maintain her benefits and entitlements. (Petitioner's Exhibit 1, pages 1-2; Respondent's Exhibit A, pages 14-15).

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).

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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

Moreover, 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

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(CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided by the CMH is targeted case management. With respect to those services, the applicable version of the Medicaid Provider Manual (MPM) provides:

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.

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- 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	<p>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.</p> <p>The case manager must review services at intervals defined in the individual plan of service.</p>

	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, October 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 74-76*

However, while the above services are covered by Medicaid, Medicaid beneficiaries are still only entitled to medically necessary covered services for which they are eligible and

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the 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.

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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- 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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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

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scientifically recognized and accepted standards of care;

- that are 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, October 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 12-14*

Here, the CMH denied Appellant's request for a reauthorization of a full year of targeted case management services and, instead, only authorized such services for another [REDACTED]. After that period, the services would be terminated.

Appellant now bears the burden of proving by a preponderance of the evidence that the CMH erred in making that decision.

Given the undisputed record and evidence in the case, Appellant and her representative have failed to meet that burden of proof and the CMH's decision must be sustained.

Appellant and her representative only note that Appellant has difficulties reading or understating document due to her mild mental retardation. However, that disability alone is insufficient to justify continuing targeted case management services where Appellant has made significant improvements over the past year, including securing benefits; obtaining a payee; completing therapy; and learning how to arrange

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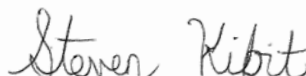
transportation to medical appointments through Medicaid. It does not appear that Appellant still needs targeted case management services and even her representative acknowledges that, while the services would still be useful, Appellant does not need them. Moreover, Appellant has reduced her LOCUS score and has informal supports/family that can assist her if necessary.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.



Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

***** 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.