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

[redacted]
Appellant

Docket No. 14-018677 CMH
Case No. [redacted]

_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted], Appellant's father, appeared on Appellant's behalf. Appellant and [redacted], Case Manager, appeared as witnesses.

[redacted], Assistant Corporation Counsel, [redacted] County Community Mental Health Authority (CMH), represented the Department. [redacted], [redacted] Clinical Supervisor, appeared as a witness for the Department.

ISSUE

Did CMH properly deny authorization for continued targeted case management services for 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. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who is diagnosed with bi-polar disorder. (Exhibit A, pp 33; Testimony)

2. Appellant lives with her parents and her two children. Appellant's parents assist her with caring for her children, scheduling appointments, and her other day to day needs. (Exhibit A, p 10; Testimony)

3. Appellant is currently receiving targeted case management, psychotherapy, treatment planning, and medication reviews with a psychiatrist through CMH. (Exhibit A, p 6; Testimony)

4. Appellant worked as an assistant manager at CVS until [redacted], when she was hospitalized following an overdose. Appellant has not returned to work since that time. Appellant has applied for Social Security benefits and her application is currently on appeal. (Exhibit A, pp 36-37; Testimony)

5. On [redacted], Appellant and her family met with CMH staff to conduct an annual assessment. (Exhibit A, pp 10-37; Testimony)

6. On [redacted], Appellant and her family met with CMH staff for her annual Person Centered Plan (PCP) Meeting. Appellant's goals relating to case management in her PCP included obtaining more income, help with appointments, more food and clothing for her and her children, help with hospital bills, and going back to school. (Exhibit A, pp 39-48; Testimony)

7. On [redacted], CMH notified Appellant that her request for continued case management services was denied because the documentation submitted did not support the need for continued case management. The CMH reasoned that Appellant had an attorney assisting her with obtaining Social Security and that once Social Security was approved, Appellant's goals regarding income, food and clothing would be met. The CMH also reasoned that Appellant's family was helping her, and could continue to help her, with appointments and going back to school. The Notice included rights to a Medicaid fair hearing. (Exhibit A, pp 5-6; Testimony)

8. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (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. [redacted] 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.

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.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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.

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
October 1, 2014, pp 12-14

Case Management services are also defined in the Medicaid Provider Manual:

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.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Chapter*
> *October 1, 2014, pp 82-84*

CMH's Clinical Supervisor testified that the [redacted] reviews requests for services and makes determinations as to the medical necessity of those services. CMH's Clinical Supervisor indicated that she had reviewed Appellant's clinical record and agreed that targeted case management was no longer medically necessary because the documentation submitted did not support the need for continued case management. CMH's Clinical Supervisor reviewed Appellant's diagnoses and living situation as well as the requirements for targeted case management. CMH's Clinical Supervisor testified that Appellant's goals relating to case management in her PCP included obtaining more income, help with appointments, food and clothing for her and her children, help with hospital bills, and going back to school. CMH's Clinical Supervisor testified that Appellant has an attorney assisting her with obtaining Social Security, so that once Social Security was approved, Appellant's goals regarding income, food and clothing would be met. CMH's Clinical Supervisor also indicated that Appellant's family could continue to help her with her appointments and going back to school, so targeted case management was not necessary to meet those goals.

Appellant's father testified that Appellant is in need of help and that the case manager assists him in helping Appellant. Appellant's father indicated that he is a senior citizen and retired, but had to go back to work part-time to ensure that there was money to meet Appellant's needs. Appellant's father testified that Appellant has applied for Social Security, but that her initial application was denied and she is in the appeal process. Appellant's father indicated that Appellant also had breast cancer when she was [redacted] and was only able to work for about another year before she was hospitalized following an overdose. Appellant's father indicated that he now keeps Appellant's medications locked up and administers the medications to her. Appellant's father testified that Appellant's case manager is a big help because there are simply a lot of things that he does not know.

Appellant testified that she needs help. Appellant indicated that she is not working currently and needs her case manager to help her find resources to support herself and her children. Appellant testified that her memory is gone and it is very difficult for her to remember things, but that her case manager reminds her about appointments.

Appellant's Case Manager testified that Appellant was hospitalized four times within a nine month period and definitely needs monitoring. Appellant's Case Manager testified that because of Appellant's memory loss, she helps Appellant schedule appointments, gives her reminders for appointments, and helps her obtain food and clothing for her children through local food banks and pantries. Appellant's Case Manager also indicated that she was going to start helping Appellant with her goal of going back to school. Appellant's Case Manager pointed out that if Appellant is working on case management tasks during her therapy sessions, then she is not really getting therapy to work on her underlying condition.

Based on the evidence presented, CMH properly denied Appellant's request for continued targeted case management services. As indicated above, all services must be medically necessary, meaning those services are, "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." Additionally, "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." Here, Appellant has an attorney assisting her with obtaining Social Security, so once Social Security is approved, Appellant's goals regarding income, food and clothing would be met. Furthermore, Appellant's family is able to assist her with her goals of making appointments and going back to school. Appellant is still authorized to receive individual therapy, group therapy, and medication reviews with a psychiatrist. Should Appellant need further assistance in the future, she can always make another request for case management services. However, at the time CMH made the decision to discontinue case management services, that decision was proper.

The burden is on Appellant to prove by a preponderance of evidence that case management services are still medically necessary. As indicated above, Appellant did not meet this burden.

DECISION AND ORDER

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

> The CMH properly denied authorization for continued case management services for Appellant.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

RJM/[redacted]

Date Signed: [redacted]

Date Mailed: [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.