STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director
MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 15-017525
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Janice Spodarek**

**Issued and entered**
**this [redacted] day of [redacted]**
**by:**
**Janice Spodarek**
**Administrative Law Judge**

## DECISION AND ORDER

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

After due notice, an in-person hearing was held on [redacted] Petitioner personally appeared. Petitioner was represented by Attorney [redacted], Staff Attorney with the [redacted] appeared as a witness.

Respondent is a subcontractor of the Michigan Department of Health and Human Services (DHHS), Community Mental Health (CMH) of [redacted] Respondent was represented by [redacted], [redacted] Corporate Counsel. [redacted] Fair Hearing officer, [redacted], Program Coordinator, and [redacted], Customer Services Coordinator, appeared as witnesses for the Respondent.

## ISSUE

Did Respondent properly propose to terminate Petitioner's Targeted Case Management (TCM) 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. Petitioner is a [redacted] year-old beneficiary of the Medicaid and SSI programs. Petitioner's diagnoses includes Bipolar Disorder, Borderline Intellectual Functioning (IQ of 70), and Attention Deficit Hyperactivity Disorder NOS who is managed by medications prescribed by her primary care physician. (Exhibit L; Testimony).

2. Petitioner had been receiving services from Respondent in [redacted] since [redacted] (Exhibit B.2). Petitioner's last service that she was receiving from Respondent at the time of the appeal at issue here were TCM, 8 hours per year. (Testimony).

3. Upon subsequent review, the Respondent determined that Petitioner no longer meets criteria for TCM pursuant to a [redacted] individualized treatment plan updated on [redacted] Plan notes indicate that Petitioner has achieved all of her treatment goals, is receiving psychotherapy and medication services from community providers chosen by Petitioner, has been referred to MRS for employment supports, reports having an active social life, mental health symptoms are stable, anticipates moving to an HHI apartment with minimal assistance and independent living skills; no longer has a Guardian. (Exhibit A; B; Testimony).

4. On [redacted] the Respondent completed a LOCUS evaluation with a LOCUS Score of 15, concluding that Petition be 'referred out to community provider then close the case'. (Exhibit B).

5. On [redacted], an Advance Negative Action Notice was sent to Petitioner informing her that her Targeted Case Management Services will be terminated effective [redacted] for the following reason: "Does not meet eligibility criteria." (Exhibit A.17-18).

6. On [redacted], Petitioner filed a timely hearing request to contest the denial of Targeted Case Management Services.

## 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 Respondent. 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 Respondent of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Lifeways CMH contracts with the Michigan Respondent of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Respondent 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.

*MPM, Mental Health and Substance Abuse Section, October 1, 2013, pp 12-13*

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.<br><br>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.
>
> *MPM, Mental Health and Substance Abuse Section, October 1, 2013, pp 74-75*

The issue here deals with the proposed close by the Respondent of Petitioner's TCM services approved at 8 hours per year. As noted, while Petitioner had been receiving more services previously, at the time of this action, the TCM services were all the services that Petitioner was receiving from the Respondent.

Here, Petitioner argues for keeping open the TCM services on the grounds that the evidence supports that she meets eligibility criteria based in part on her last annual psychosocial assessment of [redacted], that the LOCUS tool is not to be used as a single tool for assessment and that her score was skewed as she had a high level of natural supports, that Petitioner still has a severe mental illness as evidence by Exhibits B & C-therapists' evaluations, that Petitioner's mental health therapy sessions ended when her therapist left the employ of Respondent and began seeing a mental health therapist again in [redacted] when symptoms increased, and that Petitioner's Guardianship lapsed but that the Guardian is currently going through the process to reinstate Guardianship with the Probate Court.

Respondent argues that Petitioner did not meet the criteria for services because she has basically successfully participated in the services by the Respondent as evidenced by her LOCUS score of 15, that the Individual Plan of Service shows that she has met all of her management goals, that she has been referred to MRS for employment supports, that Petitioner expects to come up on the waiting list she has been placed on for 1 year for more independent living arrangements and supports, and that Petitioner is an example of an individual who has recovered as envisioned by the "Michigan Recovery and Practice Advisory" policy. (Exhibit A.). Respondent also argues that the evidence supports its action as Petitioner no longer falls under the 'most sever forms of serious mental illness' pursuant to the parameters of MCL 300.1208. (Exhibit A).

The purview of an administrative law judge (ALJ) is to review the Respondent's action and to make a determination if those actions are in compliance with DHHS's policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The ALJ at an administrative hearing must base a decision upon the evidence of record focusing at the time of the assessment. The Respondent cannot be held accountable for evidence it was unaware of at the time of its determination

After a careful review of the credible and substantial evidence on the whole records, this ALJ finds that the Respondent's actions were in compliance with its policy, and supported by the documentary and testimonial evidence taken as a whole at the time the Respondent took its action for the reasons set forth below.

Petitioner made multiple objections the Respondent's evidence. Regarding the evidence of Petitioner's therapist who left the employ of the CMH, the Respondent did not have access to these medical records; Petitioner did not make these records available to the CMH. While it is understandable that Petitioner wanted to continue treatment with her therapist who left the employ of the CMH, the Respondent cannot be held to medical evidence that it was not aware of at the time of the decision.

Petitioner also argues that some of the information here was not communicated with the Respondent due to the lapsing of the guardianship Petitioner's mother had over Petitioner. Again however, the Respondent cannot be held accountable for information not shared with the Respondent. These records, some of which were offered into evidence at the administrative hearing by Petitioner, cannot be considered in assessing the Respondent's action herein under general evidentiary rules of evidence as once again, the Respondent did not have access to them, and, was not aware of them.

As to the LOCUS tool, Petitioner's objection that it cannot be used as a singular tool is a valid objection. However, the Respondent presented much testimony and evidence that the LOCUS result was not used as a single evaluation, and that the decision here was based on a number of assessments and facts evidenced by the Individualized Plan of Service, the and the lack of actual contacts by Petitioner of the use of the TCM services.

Based on the evidence presented, the Respondent did properly deny Petitioner's request for continued 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 or her 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, Petitioner had few case management needs because she has secured housing, benefits, and was engaged in therapy. Any continued assistance Petitioner needs can be met through peer supports or community supports, as well as through her therapy, which is still authorized, based on the relevant evidence of record. Petitioner was given adequate time to get peer and community supports in place with assistance from her case manager.

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

At the administrative hearing, the Respondent indicated that Petitioner can reapply for services and she will be reassessed.

## DECISION AND ORDER

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

> The Respondent properly denied authorization for continued case management services for Petitioner based on the relevant evidence of record and available.

**IT IS THEREFORE ORDERED** that:

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

Janice G. Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Respondent of
Health and Human Services

cc: [redacted]

JS/cg

**NOTICE OF APPEAL**: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139