STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

Docket No. 2010-27593 CMH

Appellant

_____/

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 on . , Manager, appeared on behalf of the Appellant. , Appellant, was also in attendance and provided testimony.

, Due Process Manager, l Health Center (CMH), represented the CMH. , CMH Psychologist and Utilization Manager; appeared as a witness for the Department.

ISSUE

Did CMH properly propose termination of Appellant's Assertive Community Treatment (ACT) services and transition to 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. The Appellant is a old Medicaid beneficiary.

2. The Appellant is enrolled in

3. CMH contracts with Training & Treatment Innovations (TTI) to provide ACT services to CMH beneficiaries.

4. Appellant was receiving ACT services and medication reviews from at least through , as authorized in her yearly Person-Centered Plans (PCP). (Exhibit 1, p 1). Appellant's current PCP authorized ACT from through . (Exhibit1 pp 6-10). Appellant's PCP authorized ACT to be provided by CMH's agent TTI. (Exhibit 1, p 1).

5. In [redacted], CMH listed Appellant as having primary diagnoses of bipolar disorder, NOS and polysubstance dependence. (Exhibit 1, p 1).

6. In [redacted] CMH utilization department performed an audit of its agent TTI. As part of the audit's review of case files, it was noted that Appellant was not utilizing the ACT services authorized. (Exhibit 1, 11-41).

7. From [redacted] through [redacted], Appellant's progress notes reflected Appellant had consistently not acknowledged ACT members who arrived at her home, had refused to take her mental health medications and had continuously abused alcohol and other substances. (Exhibit 1, 11-41).

8. As a result of Appellant's failure to use her authorized mental health services and to abuse substances, the CMH determined she no longer met medical necessity criteria and her ACT could be terminated and she could be transitioned to case management. (Exhibit 1, 11-41).

9. On [redacted], the CMH/TTI sent an Advance Action Notice to the Appellant indicating that her ATT would be terminated and she would be transitioned to case management services, effective [redacted]. (Exhibit 1, 42).

10. The Appellant's request for hearing was received on [redacted]. (Exhibit 2).

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. 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.

The CMH Utilization Manager witness Bagale testified that CMH's audit of Appellant's TTI case file showed Appellant had repeatedly not acknowledged ACT members who arrived at her home, had refused to take her mental health medications, and had continuously abused alcohol and other substances.

The CMH representative and witness explained that CMH utilized the Department's medical necessity criteria when making service authorization. (Exhibit 1, p 4-53). The CMH witness testified that applying the medical necessity criteria to the information in Appellant's case file, the Appellant's failure to utilize her authorized mental health services and continued abuse of alcohol indicated the Appellant was not benefitting from ACT. The CMH witness noted that the Appellant had not reported any psychotic symptoms while not taking medications nor had she been hospitalized. The CMH witness explained that based on these findings the Appellant did not meet medical necessity criteria, and therefore, her ACT could be terminated and she could be transitioned to case management. The CMH witness said the CMH requested additional, more up-to-date information, and TTI supplied additional progress notes. (Exhibit 1, 11-41). The CMH witness testified that she reviewed the additional progress notes, again found that Appellant was underutilizing her ACT authorization, and at that point an Advance Action Notice was mailed to Appellant.

During the hearing, the CMH introduced evidence supporting the fact that Appellant was authorized for CMH ACT services but had failed to appropriately utilize the services from [redacted]. (Exhibit 1). The evidence also showed that the Appellant could receive mental health services through CMH case management services.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

> **2.5.B. MEDICAL NECESSITY 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 personcentered 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.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2010, page 13.*

The Appellant's representative [redacted] noted that the CMH audit did not consider progress notes dated prior to [redacted]. The Appellant's representative asserted that often a person with bi-polar disorder does not report symptoms, and therefore, because Appellant did not report symptoms did not necessarily indicate she was not experiencing psychotic symptoms.

The Appellant admitted she was not regularly taking her medication, or answering the door when ACT members knocked, and that she continued to abuse alcohol and substances. The Appellant testified that she had feelings of suicide but had not reported them.

The Appellant admitted into the record a [redacted], case note from [redacted], Appellant's psychiatrist, after CMH made its ACT termination decision. In the note, [redacted] states that Appellant is not ready for step down to case management. [redacted]r indicated Appellant had not complied with treatment since her [redacted] intake, but recently had "begun to engage on the treatment process." (Exhibit 3).

The CMH representative objected in part to admission of [redacted] note because the note was not made available to CMH before it made its ACT termination determination.

The CMH witness responded that the purpose of ACT was to ensure a person is taking their medication to avoid hospitalization. The CMH witness explained that because the Appellant was not taking her medication in months the purpose of ACT was not being met. The CMH witness added that the Appellant's TTI case file had no reported psychiatric symptoms (auditory commands) even without taking medications.

The Appellant must prove by a preponderance of evidence that the CMH termination of ACT services and transition to case management was improper, but she did not meet the burden of showing that her TTI case file and additional information demonstrated medical necessity for ACT services at the time of CMH's [redacted], negative action notice. The CMH provided credible evidence that its [redacted] termination of ACT services and transition to case management was not improper.

DECISION AND ORDER

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

> The CMH's termination of Appellant's case management and ACT services transition to case management was proper.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/15/2010

***** 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.