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. 2010-28162 CMH
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. The Appellant requested an adjournment because she wanted witnesses present. The adjournment was not contested by the CMH. This ALJ adjourned at the request of the Appellant. The hearing was rescheduled for [redacted] and completed. The Appellant represented herself at hearing. Her brother, [redacted], was present to provide testimony in support of the Appellant. The Appellant's sister-in-law, [redacted], was present to provide testimony in support of the Appellant. [redacted], the Appellant's case manager, was present. [redacted], customer service representative for the [redacted] County Community Mental Health Agency was present at the hearing.

[redacted], was present on behalf of the [redacted] County Community Mental Health Agency, hereinafter CMH. [redacted] was also present on behalf of the CMH.

ISSUE

Did the CMH properly propose to authorize ACT services on behalf of the 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. The Appellant is a [redacted] Medicaid beneficiary.
2. [redacted] County CMH is the Community Mental Health contractor with the State of Michigan. (hereinafter CMH)

3. The Appellant is a participant with CMH since at least [redacted].

4. The Appellant is diagnosed with a DSM IV psychiatric disorder, Bi-polar disorder with psychotic features. She has additional diagnosis of poly-substance abuse disorder and borderline intellectual functioning.

5. The Appellant has received services from CMH, when not incarcerated, for several years.

6. The Appellant has received ACT services in the past.

7. The Appellant currently has no stable housing or employment.

8. The Appellant has used extensive case management services since her most recent release from jail, using [redacted] minute units of in person case management in the first [redacted] days since her release into the community.

9. The Appellant's functional status is significantly impaired by her mental health status. She reported suicidal feelings and plans two (2) times in [redacted], resulting in Crisis placement. She was taken to the emergency room via ambulance in the winter of [redacted]. In December of [redacted], while in jail, she threatened to throw urine at a nurse, threatened deputies and threw food.

10. The Appellant has an extensive and lengthy criminal history that includes at least [redacted] felony convictions and [redacted] misdemeanors. Her criminal history includes violent and aggressive conduct as well as murder.

11. The Appellant has failed to make appropriate medical decisions on her own behalf, resulting in a severe infection of her leg.

12. The Appellant has a history of non-compliance with medications.

13. The Appellant has been authorized and referred for detoxification and residential substance abuse treatment in the past. She has not availed herself of the treatment offered and recommended. She lacks insight into her substance abuse problem.

14. The Appellant's current functioning level and service level are incongruent.

15. CMH is proposing to authorize ACT treatment services, a more restrictive service level for the Appellant.

16. At hearing, the Appellant threatened to harm ACT service providers should the services be authorized for her rather than case management services she desires.

17. The Appellant cited her past violent conduct perpetrated against ACT workers at hearing. She admitted to spitting on [redacted] and striking [redacted] in the face.

18. The Appellant requested a hearing March 31, 2010.

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 and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

The Appellant is entitled to Medicaid funded services through CMH if the following conditions are met:

1. She meets the service eligibility requirements per the DCH/CMHSP Managed Specialty Supports and Services Contract: Attachment 3/3/1 and/or 3.3.2

2. The service in issue is a Medicaid covered service, i.e. State Medicaid plan or waiver program service, and

3. The service is medically necessary.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. 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*. CMH required to use a person-centered planning process to identify medically necessary services and how those needs would be met pursuant to its contract with the Department of Community Health. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

The Medicaid Provider Manual defines terms in the Mental Health/Substance Abuse section dated July 1, 2009. It defines medical necessity as follows:

> Determination that a specific services I medically (clinically) appropriate, necessary to meet needs, consistent wit the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
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> Medicaid Provider Manual
> Mental Health /Substance Abuse
> Version date July 1, 2009, page 5.

The Medicaid Provider Manual further specifies Medical Necessity Criteria:

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.

2.5B. 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/aids) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professions with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on personal-centered planning, and for beneficiaries with substance use disorders, individuals 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.

2.5C. 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 the 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. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports 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, fate-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.
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> Medicaid Provider Manual
> Mental Health/Substance Abuse section
> version date July 1, 2007 pages 12-14.

[redacted] County CMH is proposing to terminate case management services for the Appellant and authorize a more restrictive level of services referred to as ACT services. The services are more intense than case management services. The Appellant is opposed to termination of her case management services and implementation of ACT services. She disputes their medical necessity. CMH asserts ACT services are medically necessary for this Appellant due to her current functional and mental health status.

The Medicaid provider Manual sets forth the eligibility criteria for participation in ACT services:

> Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. The team also provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team. All team staff must have a basic knowledge of ACT programs and principles acquired through ACT specific training.

Section 4.2 identifies the target population for ACT services:

> ACT services are targeted to beneficiaries with serious mental illness who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.
>
> - Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication compliance.

- Beneficiaries with serious mental illness with a co-occurring substance disorder.

- Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.

- Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.

- Older beneficiaries with serious mental illness with complex medical/medication conditions.

Section 4.5 provides the ACT services eligibility criteria, with regard to diagnosis, severity of illness and intensity of service.

Diagnosis
The beneficiary must have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes), including personality disorders.

Severity of Illness
Acceleration or retardation, withdrawal or avoidance, compulsions Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and are serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor/rituals, impaired reality testing and/or impairments in functioning and role performance.

- Self-Care/Independent Functioning - Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations.

- Drug/Medication Conditions - Drug/medication compliance and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify a typical side effects or concurrent physical symptoms and medical conditions.

- Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Medicaid provider manual, Mental Health & Substance Abuse Services, Section 4.5, pp. 25-26.

The Appellant testified she does not need nor want ACT services. She said she had been denied her medication while in jail but she is compliant now. She has natural supports in the community because she has a brother and sister in law. They were present to provide testimony in support of the Appellant. The Appellant was adamant in stating she will not cooperate with or participate in ACT. She then stated she will harm any ACT worker who tired to work with her like she had in the past. She also stated she would move away just to avoid having to participate in ACT.

The credible and persuasive evidence of record is that the Appellant's current functional status is such that more intensive services are medically necessary at this time. Her use of case management services and functional status are incongruent. She is too reliant on her case manager for in person contact. She has daily need for intervention to assist with appropriate decision making and in almost all areas. She must be assisted to maintain her medications, make appropriate medical decisions, appropriate behavior management decisions and control her violent and aggressive outbursts. Her conduct at hearing evidenced her need for more intense services. She uses and threatens violence when she believes she will not get what she wants. She has a history of failing to control her temper and acting on her desire to harm people as evidenced by her own admissions at hearing and multiple criminal convictions. She has inappropriate use of emergency services, suicidal feelings and thoughts and an unstable housing situation. Her current needs cannot be addressed with the case management services alone. She does exhibit evidence of disruption of self care, she does engage in behaviors dangerous to others and herself and places herself and others at risk of imminent harm. This is sufficient evidence to establish she does meet the ACT criteria set forth in policy.

Intensity of Service
ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in vivo, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.

- The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment.

- The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.

- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

- Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.

- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

Medicaid provider manual, Mental Health & Substance Abuse Services, Section 4.5, pp. 25-26.

Reviewing the intensity of services provided as ACT services it is apparent the Appellant does require the intense level of services described. Specifically, she does require "constant observation and supervision" of her behavior to "compensate for impaired reality testing, deficient internal controls and/or faulty self-preservations inclinations." She does require intensive services to restore functional living skills, prevent symptom elevation or regression.

This ALJ concurs with the Department's determination that the Appellant does require ACT services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] County CMH services properly proposes to terminate case management services and authorize Act services on behalf of the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decisions are AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/21/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 Administrative Tribunal 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