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

Appellant

______________________/

Docket No. 2010-41210 CMH

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 . The Appellant appeared without representation. His witness was ACT case manager, . hearings coordinator, represented the Department. Her witness was , utilization review manager.

ISSUE

Did the Department properly propose denial of the Appellant's services from ACT and than properly transition to Case Management?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of hearing the Appellant is a Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with: bipolar disorder, diabetes, neuropathy, depression, anxiety, and diverticulitis. (Department's Exhibit A-1 p. 4, A-2, p. 14 and Appellant's Exhibit #1 and #2)

3. On , the Appellant was denied continued placement in Assertive Community Treatment (ACT) because documentation did not support medical necessity for the ACT LOC. (Department's Exhibit A-4, p, 42-47)

4. The Appellant was provided Adequate Action Notice advising him of the denial of continued ACT services and his further appeal rights. (Department's Exhibit A-4, pp. 42, 43)

5. On [redacted], an IPOS was conducted of the Appellant with the recommendation for a follow-up in (3) three months. (*See* Testimony of [redacted] RN)

6. On [redacted], a second IPOS was conducted of the Appellant which led to the proposed change in status for lack of medical necessity for continued ACT. (Department's Exhibit A)

7. Two transition periods were authorized by Utilization Review Manager Holiday; the first ending on [redacted] and the second ending on [redacted] (*See* Testimony of [redacted] and Department's Exhibit A-4, pp. 42-45)

8. Transition services were authorized to assist the Appellant in his move to Case Management. (Department's Exhibit A-6, pp. 107-108)

9. The Appellant was last hospitalized on [redacted]. (*See* Testimony of [redacted]

10. Evidence of continued medical necessity for ACT service was not identified on review of the Appellant's chart on a detailed review conducted by [redacted]. (*See* Testimony of [redacted] and Department's Exhibit A-5, pp. 50 – 63)

11. The Appellant testified that he has many disabilities including "bipolar disorder, afraid to ride in elevators and does not eat well." (*See* Testimony of Appellant and Appellant's Exhibit #2)

12. The Appellant's witness and case manager testified that the Appellant likely did not meet the ACT criteria any longer, but rather that he demonstrated anxiety a result of his unease in leaving the ACT program. (*See* Testimony of [redacted])

13. At the close of proofs the Appellant acquiesced in the receipt of Case Management services – although he did not withdraw his petition for appeal. (*See* Testimony of Appellant)

14. The Appellant's filed the instant request for hearing, as received by SOAHR on [redacted]. (Appellant's 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 (Department) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW.

The MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1 and Attachment 3.1.1, Section III(a) Access Standards-10/1/08, page 4, directs a CMH to the Department's Medicaid Provider Manual (MPM) for determining Assertive Community Treatment for those afflicted with serious mental illness. The receipt of these intensive, individually tailored and medically necessary services and supports are targeted for those at acute risk of incarceration, psychiatric hospitalization, older beneficiaries, those with co-occurring substance disorders or those with serious mental illness having difficulty managing their medication.

Assertive Community Treatment (ACT) services are based on the principles of recovery and person centered practice and are individually tailored to meet the needs of the beneficiary – in the community.

Medicaid Beneficiaries are entitled to ACT services through [redacted] and its provider if the beneficiary continues to demonstrate medical necessity.[1]

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.

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. The SOAHR has jurisdiction to hear matters related to a denial, reduction, termination, or suspension of a Medicaid covered service. *See* 42 CFR 431.200 et seq.

[redacted] provided an Adequate Action Notice to the Appellant that they had determined that he was no longer eligible for ACT services for lack of medical necessity and that a transition to Case Management would be implemented – following a period of transition. *See* Department's Exhibit A – at pages 1 - 119

The Department denied further authorization because his symptoms and functioning had improved and he no longer met the medical necessity standards for ACT services. A transition period of (5) five weeks was authorized to assist in shifting the Appellant to Case Management.

[1] *See* Medicaid Provider Manual at §2.5 – 2.5.D, Mental Health [ ], July 1, 2010, pp. 12-14

The Medicaid Provider Manual (MPM) sets forth the overall goals and eligibility for the highly intensive and restrictive ACT program:

SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. Michigan adopted a modified ACT model in the 1980's tailored to Michigan service needs. While a PIHP is free to use either the Michigan ACT model or the federal Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model, with prior Department approval, the use of the Michigan model is strongly encouraged.

ACT 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 ACT team staff must have a basic knowledge of ACT programs and principles acquired through MDCH approved ACT specific training within six months of hire, and then at least one MDCH approved ACT specific training annually.

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ELIGIBILITY CRITERIA

Utilization of ACT services in high acuity conditions/situations allows beneficiaries to remain in their community residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. <u>This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT</u>. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's

needs and condition. Services include availability of multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multidisciplinary team which includes psychiatric and skilled medical staff.

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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).

Severity of Illness 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 is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/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 adherence and/or a 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 atypical side effects or concurrent physical symptoms and medical conditions.

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Discharge Cessation or control of symptoms is not sufficient for discharge from ACT. Recovery must be sufficient to maintain functioning without support of ACT as identified through the person-centered planning process.

> ● The beneficiary no longer meets severity of illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to demonstrate clinical stability. Beneficiaries who meet criteria for ACT services usually require and benefit from long term participation in ACT. If a beneficiary requests transition to other service(s) because he believes he has received maximum benefit, consideration for transition must be

> reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised Individual Plan of Services developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for reenrollment in ACT services, if needed.

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MPM, Mental Health [ ] §§4 through 4.5, pp. 23 – 28.[2]
(Emphasis supplied)

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The Appellant said he is bipolar and has anxiety. He submitted evidence documenting a disability from the social security administration. The Appellant stated that he "…wanted to stay with ACT, but if [he] had to go to case management, then [he] would go to case management."

The Department witnesses testified that on utilization review the Appellant's progress indicated that he was functioning at the case management level of support, was in generally good condition, compliant with his medication and no longer demonstrated medical necessity for ACT enrollment. The Appellant's consistent improvement was documented in his person centered plan between the pages` 49 and 63 as reviewed by utilization review manager, .

also testified that the Appellant had not been hospitalized since

The Department witness testified and produced credible medical evidence that the Appellant no longer met the eligibility criteria as one afflicted with a serious mental illness that required the intensive services and supports afforded via the ACT program.

With documentation of stability apparent in the record as reflected in person centered planning the Appellant no longer meets medical necessity criteria for ACT services. The Department provided sufficient evidence that the Appellant was no longer eligible for ACT. Furthermore, based on the documentation the Appellant has demonstrated medication stability, general improvement in condition, the absence of depression and a lack of recent hospitalization.

The Appellant did not preponderate as one with a serious mental illness requiring the continuation of intensive, individualized services and supports of the ACT program. He

[2] With the exception of a delegation/credentialing adjustment for physician supervised staff at section 4.3 (not cited above) this edition of the MPM is substantially similar to the version in place at the time of the Appellant's request for hearing.

testified that he is prepared for case management. His witness supported that conclusion.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant no longer met the requirements for ACT services. The Department properly denied continued ACT services.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

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Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: ______________________

***** 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.