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) 334-9505

IN THE MATTER OF:

[redacted],

Appellant

_____/

Docket No. 2011-34299 CMH
Case No. [redacted]

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 [redacted]. The Appellant appeared without legal representation. Her sister, [redacted] appeared and testified on her behalf.

[redacted], attorney, represented the CMH. Her witness was [redacted], Supervisor of the [redacted].

ISSUE

Did the Department properly terminate Assertive Community Treatment (ACT) to 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. At the time of hearing, the Appellant is a [redacted]-year-old Medicaid, Medicare, SSI, beneficiary. (uncontested)

2. The Appellant is afflicted with schizophrenia and multiple chronic and serious physical ailments, including COPD, which leaves her oxygen dependent at all times. (uncontested)

3. The Appellant has a history of multiple in-patient psychiatric hospitalizations. (Department's Exhibit A)

4. The Appellant has not been hospitalized for in-patient psychiatric treatment since [redacted]. (Department's Exhibit A)

5. The Appellant has been receiving mental health treatment through [redacted] Community Mental Health, specifically participating in ACT treatment services since [redacted]. (Department's Exhibit A)

6. The Appellant was recently evaluated for continuation in ACT services through CMH. (Department's Exhibit A)

7. The service needs evaluation resulted in a determination the Appellant no longer requires ACT services. (Department's Exhibit A)

8. The determination the Appellant no longer meets eligibility criteria for ACT services was based upon the determination that she is psychiatrically stable, is exhibiting only mild symptoms of her mental illness and her functioning (from a psychiatric standpoint) has improved and stabilized. (Department's Exhibit A)

9. The Appellant is compliant with her psychiatric medications. (Department's Exhibit A)

10. The Appellant was provided Advance Notice advising her of the termination of ACT services and her further appeal rights. (Department's Exhibit A)

11. The Appellant filed a request for formal, administrative hearing received by the Michigan Administrative Hearing System on [redacted].

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, [page 4], directs a CMH to the Department's Medicaid Provider Manual (MPM) for determining Assertive Community Treatment eligibility 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 MCCMHSP and its provider if the beneficiary demonstrates medical necessity.

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.

[redacted] CMH provided an Advance Negative Action Notice to the Appellant that she was no longer eligible for ACT services for lack of medical necessity. The plan as documented

in the evaluation is for a transition to case management and psychiatric services to be provided during the transition period. *See* Department's Exhibit A.

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

> **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.
>
> ****
>
> **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. 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.

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.

****

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.

- 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 medial/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.

Intensity of Service ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, 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 nad 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.

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.
>
> ● Engagement of the individual in ACT is not possible as deliberate, persistent and frequent assertive team outreach including face-to-face engagement attempts and legal mechanisms, when necessary, have been consistent, unsuccessful, and documented over many months; and an appropriate alternative plan has been established with the beneficiary.
>
> ● Beneficiary has moved outside of the geographic service are and contact continues until service has been established in the new location.
>
> MPM, Mental Health/Substance Abuse,
> January 1, 2011, pp. 23-28.

The Appellant and her witness testified that she has multiple medical problems and she relies on ACT staff to discuss problems, manage medications and assist in keeping her stable. She did not dispute the evidence from the CMH that she is compliant with medication, has not required in patient psychiatric hospitalization for years and is presenting with mild symptoms. The CMH witness stated the CMH wants the Appellant to obtain her medications from her primary care doctor. The Appellant's sister stated at hearing that the Appellant is not going to be able to obtain her medications from her primary care doctor because the doctor refused to prescribe them for her. The CMH countered with testimony, based upon progress notes from a contractor who was not present for hearing, indicating the doctor's staff said the doctor has a willingness to prescribe medications but must see the patient face to face in order to do so.

After review of the criteria for ACT services and the evidence of record, this ALJ does concur with the CMH that the Appellant does not meet eligibility criteria to continue receiving these services at this time. According to the evidence of record, the Appellant does not exhibit

severe symptoms of her mental illness such that her functioning (self care) is significantly impaired, nor is her judgment so poor that she poses a risk to herself or others, nor is she placing herself in dangerous situations due to uncontrolled symptoms of mental illness. She is compliant with medications. This ALJ also notes the evaluation presented by the CMH does repeatedly state the Appellant does still experience break through mental illness symptoms and has increased anxiety around her multiple medical issues and termination from services. She is historically resistant to relying on natural supports alone to remain compliant with medication. She does exhibit resistant and dependent behaviors around obtaining her medications as evidenced by the ACT team notes put into evidence by the Department. She did not follow up with making and keeping a medical appointment with her primary care physician for the purpose of obtaining her psychiatric medications, over multiple contacts and follow ups. There was no evidence of a new IPOS or plan to develop one to address continued mental health treatment needs. Nor was there a Notice issued to the Appellant explicitly informing her she was no longer eligible for any mental health treatment services provided by CMH. Her Notice addressed only eligibility for ACT services.

This ALJ must address the fact that the Medicaid Provider Manual explicitly addresses discharge from ACT services. Of note is the explicit statement that:

> 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.

This ALJ read the evidence submitted by the CMH and did not see any evidence of a plan to develop a new IPOS. The transition plan was only for the Appellant to obtain her psychiatric medications from her primary care physician. However, the hearing that resulted from the Notice sent the Appellant pertained only to eligibility for ACT services. The hearing was limited to this issue because that is all the Appellant was provided Notice of. Should the CMH determine the Appellant does not meet eligibility criteria for any service provided for seriously mentally ill people, a Notice must be sent to her apprising her she no longer meets service criteria for any mental health treatment through CMH and providing Notice of hearing rights.

While the Appellant's evidence addressed her desire for a convenient service based on a perceived inability to obtain medication through her primary care physician, the ACT discharge criteria stated in the Medicaid Provider Manual controls how discharge is to be effected. It must include development of an IPOS.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant no longer meets eligibility criteria for ACT services and must have a new IPOS developed.

IT IS THEREFORE ORDERED that:

The Department's decision to terminate ACT services is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/18/2011

***** 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.