STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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. 2011-9056 CMH
Case No. 20707478

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 [redacted].

[redacted] Appellant's [redacted], appeared on behalf of the Appellant. Also in attendance and providing testimony were Appellant [redacted] and her [redacted].

[redacted], [redacted] Community Mental Health Authority (CMH), represented the Department. [redacted] 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 [redacted] Medicaid beneficiary. Appellant is also enrolled in Medicare Parts A, B, and D. (Exhibit C).

2. The Appellant is enrolled in [redacted] CMH, but not in any of the specialty waivers.

3. The Appellant has been receiving CMH services since approximately [redacted].

4. Appellant has a primary diagnosis of schizo-effective disorder, bipolar type. (Exhibit D, p 29). Appellant takes the daily oral medication, Cogentin, and receives an injection one time per month as her mental health medication treatment. (Exhibit D).

5. Appellant was receiving ACT services and medication reviews from at least [redacted], as authorized in her yearly Person-Centered Plans (PCP). (Exhibit D).

6. Appellant's [redacted] authorized ACT was provided by CMH's agent, [redacted]. (Exhibit D, p 26).

7. In [redacted], CMH agent [redacted] performed a yearly assessment in preparation for development of her [redacted] Person-Centered Plan. As part of the review, it was noted that Appellant had not been hospitalized in the prior four years, was relatively stable, and used only the minimal amount of the ACT services authorized. (Exhibit F).

8. From [redacted], Appellant's progress notes reflected Appellant's only in-home ACT service was a monthly visit from her case manager. The assessment and her progress notes indicated that Appellant went to the office to receive her mental health injection medication one time per month. (Exhibits, D, F, G).

9. As a result of Appellant's stability and minimal use of ACT mental health services, [redacted] determined and the CMH concurred she no longer met medical necessity criteria, her ACT could be terminated, and she could be transitioned to case management. (Exhibit D).

10. [redacted] and the CMH recommended a several month step-down for Appellant to transition from ACT with [redacted], to case management with [redacted]. (Exhibit D, page 35).

11. On [redacted], the CMH [redacted] sent Advance Action Notices to the Appellant indicating that her ACT would be terminated and she would be transitioned to case management services, effective [redacted]. (Exhibit A).

12. 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 [redacted] testified [redacted] performed an assessment of Appellant and determined that although it appeared that ACT helps the Appellant, the Appellant no longer met the medical necessity criteria for ACT.

The CMH witness explained that CMH utilized the Department's medical necessity criteria when making service authorization. (Exhibit J). Medical necessity is met when a person has seriously impaired ability for self-care and for interactions with others, non-adherence to a medication schedule, and a risk to self and others. (Exhibit J, page 79). The CMH witness explained that when reviewing Appellant's medical documentation it reflected that Appellant was doing well with her recovery, her hygiene had improved, she had not had any hospitalizations, she was more active in the community, and there was only one visit to the home per month for case management. The CMH witness testified that applying the medical necessity criteria to the information in Appellant's case file, the Appellant's improvement in self-care and adhering to medication schedule, absence of hospitalizations and minimal use of her authorized mental health services indicated the Appellant no longer met the medical necessity criteria for ACT.

The CMH witness explained that based on the [redacted] findings the Appellant did not meet medical necessity criteria, her ACT could be terminated and she could be transitioned to case management. The CMH witness said the CMH concurred with the decision, including the prolonged transition from [redacted].

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's 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 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2010, page 13.

The Appellant's [redacted], noted that the transition from ACT services to case management services meant the Appellant's provider would change from [redacted] to [redacted]. The Appellant's [redacted] explained that the Appellant's stability in part was due to the [redacted] provider. The Appellant's [redacted] asserted that when the Appellant received services from [redacted] she was hospitalized four times, and showed serious psychiatric symptoms such as shutting herself in her room and talking to herself. The Appellant's [redacted] gave the [redacted] example of Appellant being found in a car with an open gas can, putting gas on her hands and face and breathing in fumes.

The Appellant testified that she did not want to go to [redacted] because she had had some problems there in the past, including giving her medications that gave her side effects.

Appellant's [redacted] asserted that Appellant should remain in ACT with [redacted] because all the other programs had failed, and [redacted] did not meet her needs.

The CMH witness made the distinction that although [redacted] and CMH may believe that Appellant was doing well in ACT, the Appellant must meet the medical necessity criteria for ACT in order for Medicaid to pay for the ACT services.

The Appellant's [redacted] said it was difficult for the Appellant to go to an office for her monthly injection, but the medical documentation showed that the Appellant had been successfully going to an office for her injection for more than a year.

The Appellant must prove by a preponderance of evidence that the CMH termination of ACT services and transition to case management was improper because she did meet medical necessity criteria for ACT services. While there is no dispute among the parties or this administrative law judge that the ACT program helps the Appellant, a preponderance of the evidence does not demonstrate that she met medical necessity criteria for ACT services. The Appellant did not meet the burden of showing that her [redacted] case file and additional information demonstrated medical necessity for ACT services at the time of [redacted]/CMH's [redacted] ACT eligibility determination. The CMH provided credible evidence that its [redacted] determination to terminate 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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/14/2011

***** 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.