

**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

██████████

Appellant

\_\_\_\_\_ /

Docket No. 2011-7578 CMH  
Case No. 16744976

**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. Her witness was ██████████, represented the CMH. Her witness was ██████████.

**ISSUE**

Did the Department properly deny 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 ██████████ Medicaid, Medicare, SSI, beneficiary. (Appellant's Exhibit #1)
2. The Appellant is afflicted with; bipolar 1 disorder, most recent episode mixed, severe w/pysch [sic], ADHD NOS, OCD and depression. (Department's Exhibit A, pp. 17, 27 and Appellant's Exhibit #1)
3. On ██████████, the Appellant was denied placement in Assertive Community Treatment (ACT) for lack of medical necessity. (Department's Exhibit A, pp. 1-4)
4. The Appellant was provided Adequate Action Notice advising her of the denial of ACT services and her further appeal rights. (Department's Exhibit A-4, pp. 5-8)

5. The Appellant is currently prescribed Depakote ER, Progesterone. (Department's Exhibit A, p. 1)
6. The Appellant reports no hospitalizations in two years and no medications in over a year. (Department's Exhibit A - throughout)
7. On [REDACTED] the Appellant accepted a referral to [REDACTED] for case management and psychiatric services. The referral was facilitated by [REDACTED]. (Department's Exhibit A, p. 38)
8. The Appellant testified that she needs special accommodation owing to her mental illness issues and lack of transportation. She further believes she was rejected by the program owing to the personal prejudice of one of the eligibility specialists. (See Testimony of [REDACTED], Appellant's Exhibit #1 and Department's Exhibit A, p. 3)
9. The Appellant is being served as a person with a serious mental illness through the MCCMH mental health outpatient clinic. (Department's Exhibit A, pp. 3, 35)
10. The Appellant filed the instant request for hearing, as received by State Office of Administrative Hearings and Rules 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, [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.<sup>1</sup>

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 provided an Adequate Action Notice to the Appellant that they had determined that she was not eligible for ACT services for lack of medical necessity and that a

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<sup>1</sup> See Medicaid Provider Manual at §2.5 – 2.5.D, Mental Health [ ], January 1, 2011, pp. 12-14

transition to case management and psychiatric services would be implemented. See Department's Exhibit A, pp. 1-37.

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.

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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. 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.

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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, January 1, 2011 pp. 23 – 28.<sup>2</sup>

The Appellant and her witness testified that she had a medication problem – largely related to not taking medication. The Appellant said that her situation, in the request for ACT services, was aggravated by the prejudicial actions of her eligibility reviewer whom she suspected was harboring animus for “not opening a door” [for her] – on a home call at some point in the past.

Her [REDACTED] said that he must travel from [REDACTED] to ensure her medication compliance.

The Department witness, [REDACTED], testified that the Appellant had no hospitalizations in over two-years and had not taken medications for over one-year. Furthermore, the Appellant had maintained overall stability and all of her supports during the same time period without program involvement. [REDACTED] concluded with the observation that the Appellant is stable in the community and is able to be served in a less restrictive environment - such as case management.

With documentation of stability apparent in the record and assessment of the Appellant, it is clear that she does not meet the medical necessity criteria for ACT services. The Department provided sufficient evidence that the Appellant was no longer eligible for ACT. Furthermore,

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<sup>2</sup> This edition of the MPM is identical to the version in place at the time of the Appellant's request for hearing.

based on the documentation and her own testimony, the Appellant has demonstrated stability, general improvement in condition, and the lack of recent hospitalization.

The Appellant's proofs spoke to her desire for a convenient service based on a lack of transportation and her perception of a grudge held against her by her former worker. The Appellant did not preponderate as one with the severity of illness requiring the intensive, individualized services and supports of the ACT program.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant did not meet the requirements for ACT services. The Department properly denied ACT services.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

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Dale Malewska  
Administrative Law Judge  
for Olga Dazzo, Director  
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 2/17/2011

**\*\*\* 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.