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) 373-4147

IN THE MATTER OF:

Docket No. 2013-40911 CMH
[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] [redacted] LBSW, Advocate for [redacted] appeared and testified on the Appellant's behalf. Appellant appeared and gave testimony on his own behalf. Appellant's wife, [redacted] also testified for the Appellant.

Attorney [redacted], Corporation Counsel for [redacted] County Community Mental Health and Substance Abuse Services, hereinafter CMH, represented the CMH. [redacted], MA, LPC, LBSW, CAADC, Quality Improvement Manager for CMH, was present and gave testimony on behalf of the CMH.

ISSUE

Did the CMH properly deny Appellant's request for Assertive Community Treatment (ACT) services based upon a finding that ACT services were not medically necessary?

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 Medicaid beneficiary who has been receiving mental health services.

2. [redacted] County Community Mental Health and Substance Abuse Services is the Community Mental Health contractor with the [redacted]. (hereinafter CMH)

3. The Appellant is a participant with CMH and started receiving ACT services through an agency who contracts with the CMH to provide ACT services, on His Act level services include a payee/conservator. (Exhibit A, p. 15).

4. The Appellant has been diagnosed with bipolar disorder, most recent episode depressed, PTSD, alcohol dependence, cannabis dependence, and personality disorder, NOS. (Exhibit A, p. 14).

5. On CMH determined Appellant no longer benefitted from his ACT services and he was given an Advance Action Notice advising that his Act services would be terminated effective (Exhibit A, pp. 3-4).

6. On Appellant's request for hearing was received by MAHS.

7. On Appellant filed a local appeal of the decision to terminate his ACT services. (Exhibit A, pp. 1, 5).

8. On MA, LPC. LBSW, CAADC, Quality Improvement Manager for CMH conducted a Utilization Management Review. recommended that Appellant's ACT services be terminated, and that he should receive outpatient substance abuse services to treat his primary presenting problem of substance use. (Exhibit A, pp. 9-20).

9. On , Appellant was sent a letter by CMH advising him that they were upholding their termination of ACT services. (Exhibit A, pp. 5-6).

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.

stated she was the Quality Improvement Manager for CMH and is a Licensed Professional Counselor, a Licensed Bachelor Social Worker, and a Certified Addiction Counselor. stated she did a clinical records review of the Appellant's records from on the agency that contracts with CMH to provide ACT services for the Appellant. She noted Appellant had a psychiatric evaluation at but was not receiving any psychiatric services through .

stated services have increased the Appellant's integration into the community. She stated progress notes show that substance abuse was the main focus of the Appellant's treatment. Appellant wanted to decrease his use of alcohol and he is down from drinking up to a case of beer per day to at most a 6 pack per day. The notes also show that Appellant also engages in some marijuana use. noted some more intensive substance abuse treatments were attempted by the Appellant, but Appellant did not follow through with the treatment, and substance use and abuse remains the main focus of his treatment at t. stated prior to CMH's decision to discontinue ACT level services; Appellant had gotten quite stable as far as his mental health issues

were concerned. His mood was affected and his anxiety did increase as a result of their decision to discontinue his ACT level services.

stated Appellant's instability was being caused by his substance abuse. Substance abuse was a significant concern for the Appellant, and mental health issues in general were not a significant concern. stated due to the progress he has made with his ACT services through , he no longer was in need of that level of behavioral health services, and his primary concern of substance abuse would be better served through the less restrictive level of services available through Substance Abuse services. referenced the Medical Necessity Criteria in the Medicaid Provider Manual and stated the PIHP was justified in discontinuing ACT level services as they are no longer medically necessary to treat Appellant's behavioral health issues, and the less restrictive services available through Substance Abuse services would be more effective in treating the Appellant's substance abuse concerns.

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 is 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 April 1, 2013*. It defines medical necessity as follows:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with 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, April 1, 2013, p. 5.*

The *Medicaid Provider Manual* further specifies Medical Necessity Criteria:

> **2.5.A. Medical Necessity Criteria**
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> **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.

2.5.B. 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.

2.5.C. 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.

Medicaid Provider Manual, Mental Health/Substance Abuse Section, April 1, 2013, pp. 12-14.

County CMH is denying ACT level services for the Appellant and has authorized instead a less restrictive level of services through Substance Abuse services. The Appellant has asked to continue his ACT services and not step down to Substance Abuse services. CMH asserts that the less restrictive services available through Substance Abuse services would be more appropriate to meet the Appellant's current needs.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Assertive Community Treatment Program, Section 4* gives a description of ACT services. It states in part:

> 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.

Section 4.2 identifies the target population for ACT services:

> ACT services are targeted to beneficiaries with serious mental illness, which may include personality disorders, 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 adherence.
> - 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).

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 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 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, p. 27.

, LBSW, Advocate for , which was providing the ACT level services for the Appellant, testified that the Appellant's most recent GAF might indicate he still needs ACT level services. further testified, however, that they recognize what the utilization review has shown. indicated has worked with the Appellant two times per week, and they believe they have saved his life. He stated Appellant has cut out drinking hard liquor, and has cut down on the amount of beer he drinks. He also acknowledged the Appellant's marijuana use. suggested that the Appellant's drinking and marijuana use go together. also stated the Appellant has not been willing until recently to have any medications prescribed for him.

stated the Appellant does need some level of services, but it is questionable whether he still needs ACT level services. He stated Appellant has done a good job of getting his life together. He also admitted has focused on substance abuse with the Appellant along with his co-occurring mental health issues. stated he wants ongoing services for the Appellant, even if ACT level services are not continued.

The Appellant testified he did not think all the information reviewed was accurate. He said he doesn't want to lose the t ACT team. Appellant said his drinking has gone way down. He stated he needs his medications, and they are starting him on Seroquel. Appellant stated he wasn't taking his medications before because he was drinking. Appellant stated he only has and his wife to support him. He believes he has been more accountable with ACT services, and that InterAct has kept him alive. Appellant also said he has to keep seeing for services in order to meet his Medicaid spend down or he will lose his medical insurance.

Appellant's wife stated she believed some of the information CMH reviewed was not up to date. She further stated the Appellant doesn't have many friends that support him. The Appellant's wife said she works and that is why the Appellant's spend down is so high. She further stated if her husband loses ACT services she believes she will have to cut back on her work hours and stay home to take care of the Appellant.

The credible and persuasive evidence of record demonstrates the Appellant's current functional status is such that he no longer needs the more intensive services provided by ACT level services. As correctly pointed out by Appellant's primary concern is substance abuse and not behavioral health or mental health issues. CMH has presented sufficient evidence to establish that the Appellant does not meet the ACT criteria set forth in policy, and the less restrictive services available through Substance Abuse Services would be more appropriate to meet the Appellant's current needs.

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 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. 27-28.

Reviewing the intensity of services provided as ACT services it is apparent the Appellant does not require the intensive level of services described. CMH concluded that a step down to Substance Abuse services would be more appropriate at this time to treat the Appellant's main concern of substance use and abuse. It is not appropriate to continue any type of CMH services just so the Appellant can meet his spend down in order to maintain his medical insurance.

This ALJ concurs with the Department's determination that the Appellant does not require ACT level services and that the less restrictive services available through Substance Abuse services would be more appropriate to treat the Appellant's current needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that County CMH services properly denied Appellant's request to continue ACT level services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed:

Date Mailed:

WDB/db

cc:

***** 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.