

**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. 2014-30793 CMH
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on her own behalf.

██████████ Due Process Hearings Coordinator, appeared on behalf of ██████████ Community Mental Health (CMH or Department). ██████████, Clinical Program Manager, ██████████, and ██████████, Clinical Director, ██████████, appeared as witnesses for the CMH.

ISSUE

Did ██████████nty Community Mental Health (CMH) properly deny Appellant's request for Assertive Community Treatment (ACT)?

FINDINGS OF FACT

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

1. Appellant is a ██████████ Medicaid beneficiary, born ██████████. Appellant is diagnosed with bi-polar disorder; panic disorder with agoraphobia; post-traumatic stress disorder; sedative, hypnotic, or anxiolytic dependence; and borderline personality disorder. (Exhibit B, p 5; Testimony).
2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.
3. Appellant is a Medicaid beneficiary receiving services through ██████████ Community Mental Health Association (CMH). Appellant's current services include targeted case management (CM) through Training and Treatment Innovations ██████████ an agency contracted through CMH. Appellant is also eligible

for Dialectical Behavioral Therapy (DBT), but has been unable to attend the therapy because of transportation issues. (Exhibit B, p 3; Testimony)

4. Appellant lives alone in an apartment. (Exhibit B, p 2; Testimony).
5. From ██████████ through ██████████, Appellant was enrolled in Assertive Community Treatment (ACT) through ██████████. Because Appellant did not think she was getting sufficient treatment through ACT, she agreed with her therapist to transfer to DBT services. Beginning in ██████████, a transition plan was put in place to assist Appellant with the transfer. Appellant participated in the transition plan, but has been unable to attend DBT because of transportation issues. DBT also includes CM services, which Appellant has been participating in. (Exhibit 2, pp 7-11; Testimony)
6. When the transportation issues could not be worked out, Appellant requested a return to Assertive Community Treatment (ACT) because the therapy in ACT could be done in her home, while the therapy through DBT had to be done at the therapist's office. The request was reviewed by ██████████ and it was determined that ACT would be denied because it was not medically necessary or clinically appropriate for Appellant. (Exhibits A, B; Testimony).
7. On ██████████, Appellant was sent an Adequate Action Notice informing her that ACT was denied because it was not medically necessary or clinically appropriate. Appellant's notice included a notice of hearing rights. (Exhibit C, pp 1-2; Testimony).
8. Appellant's request for hearing was received by the Michigan Administrative Hearing System on ██████████. (Exhibit 1).
9. Prior to the hearing, Appellant submitted additional documents for review, which are found in 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 she 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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. 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 *Medicaid Provider Manual, Mental Health/Substance Abuse* section articulates Medicaid policy for Michigan. It states with regard to medical necessity and Assertive Community Treatment (ACT):

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

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/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.

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 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. Inpatient, licensed residential or other segregated settings shall be used only when less

restrictive levels of treatment, service or support 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, gate-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 Chapter
January 1, 2014, pp 12-14*

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.

4.2 TARGET POPULATION

ACT services are targeted to beneficiaries who are diagnosed 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.

4.5 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.

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.

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- 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 personcentered 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 area and contact continues until service has been established in the new location.

*Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
January 1, 2014, pp 24-29*

██████████ Clinical Program Manager testified that Appellant is currently receiving Case Management (CM) services, which look to link, monitor and coordinate resources with Appellant, which, ██████████ Clinical Program Manager opined, is very important for Appellant. ██████████ Clinical Program Manager also indicated that Appellant is eligible for DBT services but is not yet participating because of transportation issues. ██████████ Clinical Program Manager testified that in ██████████ Appellant chose to transition from ACT services to DBT/CM services and a transition plan was put in place. The plan was for the transition to take place over several months so Appellant would be comfortable. ██████████ Clinical Program Manager testified that a plan was developed, but Appellant refused to sign the plan, not because she disagreed with the transfer to DBT, but because she objected to the diagnoses listed in the plan. ██████████ Clinical Program Manager indicated that a proposed policy change indicates that ACT would not be appropriate for someone with Appellant's diagnoses.

██████████ Clinical Program Manager testified that in her professional opinion, CM and DBT services are the most clinically appropriate for Appellant and are the only services that meet medical necessity criteria for Appellant at this time. ██████████ Clinical Program Manager testified that she based her opinion on the fact that she had worked with Appellant while she was in ACT and that Appellant had maximized the gains she was going to make in that intensive program. ██████████ Clinical Program Manager testified that it was time for Appellant to transition to a level of services that would lead to even more independence for Appellant. ██████████ Clinical Program

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Manager also testified that Appellant's LOCUS scores have increased over time, which further supports the transition, but she did admit that the two most recent LOCUS reports recommended that Appellant should be in ACT. ██████ Clinical Program Manager testified that while LOCUS scores are considered in an assessment of medically necessary treatments, LOCUS scores are not the only consideration.

█████ Clinical Director testified that Appellant requested a transfer from ACT to DBT/CM services, a transition plan was put in place, and Appellant participated in the transition plan. ██████ Clinical Director testified that DBT is very appropriate for someone with Appellant's diagnosis of borderline personality disorder and would be very useful to Appellant. ██████ Clinical Director testified that during the transition period, Appellant requested to return to ACT and that the request was reviewed by a committee of 9 members. Following the review, it was determined that ACT was no longer clinically appropriate for Appellant and that DBT/CM services were clinically appropriate and met the medical necessity criteria in the Medicaid Provider Manual.

█████ Clinical Director testified that the main issue that arose during the transition period was the issue of transportation. ██████ Clinical Director indicated that while Appellant was in ACT, her therapy was conducted in her own home, but once Appellant transferred to DBT/CM, therapy would be held in an office. ██████ Clinical Director testified that Appellant was not comfortable with the transportation options offered by ██████ which included local public transportation or transportation via ██████ own vans. ██████ Clinical Director testified that they are still working on finding an alternative that would be acceptable to Appellant. One option ██████ is considering, according to ██████ Clinical Director, is that ██████ would have the DBT therapist ride with Appellant either in public transportation or in ██████ vans until Appellant became comfortable. ██████ Clinical Director testified that in her professional opinion, CM and DBT services are the most clinically appropriate for Appellant and are the only services that meet medical necessity criteria for Appellant at this time. ██████ Clinical Director also testified that this opinion was shared by the 9 member review team that reviewed Appellant's request.

Appellant testified that she was in ACT from ██████ until ██████ and that she requested a change to DBT because she was unhappy with the services she was receiving in ACT. Appellant testified that she mentioned the issue with transportation to ██████ even before she made the decision to transfer to DBT and she was repeatedly told that ██████ would take care of the issue. Appellant testified that, because of her diagnoses, she is uncomfortable taking either public transportation or the ██████ van and, as such, she has not been to any therapy since ACT was terminated. Appellant testified that she requested a return to ACT once it was clear to her that the transportation issue had not been resolved. Appellant indicated that her request was denied and she requested a local appeal, which upheld the decision to deny her ACT. Appellant testified that she requires ACT, that ACT is clinically appropriate and medically necessary for her, and that ██████ did not follow proper discharge procedures when she was terminated from ACT.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of the evidence, that CMH's denial of her request to return to ACT was improper. Here, two clinical professionals testified at the hearing that the most clinically appropriate service, and the only

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service that meets medical necessity criteria for Appellant, is DBT/CM. This decision was also supported by 9 professionals who reviewed Appellant's request to return to ACT when that request was made. While Appellant disagrees with that decision, it is clear from the evidence that the only reason Appellant is not currently in DBT is because of transportation issues, not because Appellant really thinks that DBT is clinically inappropriate for her. If Appellant thought DBT was clinically inappropriate, she never would have asked to be transferred from ACT to DBT in the first place. However, once it became clear to Appellant that the transportation options offered to her by ██████ were not to her liking, she started to argue that DBT was inappropriate and she needed to be in ACT. Such reasoning, while understandable, does not lead to the conclusion that DBT is inappropriate for Appellant.

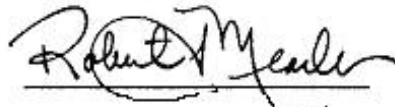
This administrative law judge must follow the CFR and the state Medicaid policy, and is without authority to grant services not in accordance with the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when not authorizing ACT to Appellant. As indicated above, medically necessary services are those that are "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 . . ." Here, the services Appellant currently is entitled to are sufficient in length, scope and duration to reasonably meet Appellant's needs. Hopefully, the parties can work together to solve the transportation issue that is at the crux of this case. However, Appellant, who bears the burden of proving by a preponderance of evidence that ACT should be covered, did not meet that burden.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied Appellant request for ACT.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

RJM/██████

Date Signed: _____

Date Mailed: _____

[REDACTED]

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[REDACTED]

***** 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.