RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 21, 2016
MAHS Docket No.: 16-006002
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. Petitioner [redacted] and [redacted], of [redacted] appeared on behalf of the Petitioner. [redacted], Fair Hearing Officer, [redacted], Utilization Manager of Adult Services appeared to testify and represent the [redacted] Community Mental Health (CMH or Department or Respondent).

Respondent's Exhibit A pages 1-48 were admitted as evidence.

ISSUE

Did Community Mental Health (CMH) properly propose to cancel Petitioner's Assertive Community Treatment (ACT) 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. Petitioner is a [redacted] year old, DOB [redacted].

2. Petitioner lives independently in her own apartment.

3. Petitioner is diagnosed with Schizoaffective Disorder, unspecified cannabis use disorder, severe as her secondary diagnosis.

4. Since [redacted], Petitioner has been receiving Assertive Community Treatment (ACT).

5. On [redacted], ACT Services were denied effective [redacted], by the [redacted] Utilization Manager.

6. ACT Services are being provided by [redacted] and services were requested for another year but were approved at a reduced rate of four months.

7. Notice was sent Petitioner of the changes in services stating: "Another year of ACT services was requested, however, four months were approved to allow for a smooth transition to less intense service. You have demonstrated great success in your recovery in mental health, and your symptoms are not impacting your daily functioning. The reason for the action is: Medical Necessity; the services requested or current services it identified in this notice are not medically necessary for the following reasons: the documentation provided does not establish medical necessity."

8. On [redacted], the Action notice and Hearings rights for Medicaid Beneficiaries denial notice was mailed to Petitioner by [redacted] customer Service.

9. On [redacted], Petitioner filed a request for hearing stating," paranoia and anxiety from my illness are so bad I can't go out and pay my bills and buy groceries without help. I have stayed out of the hospital but I am so sick I can't leave the house without someone with me. I haven't had therapy at [redacted] in years for this problem. I still have lots to work on with them. I can't go to [redacted] because I can't leave the house to get there and it's so busy it scares me. I'm scared if I leave [redacted] they will put me in home care and I hated those place please help me.

10. On [redacted], Petitioner filed a Local appeal stating that her "mental illness is progressing over the years getting worse, confined to my apartment accept when ACT comes to get me to get groceries and pay bills." She also states, "I'm inside my apartment 23 hours a day only out at the most an hour and it's with someone."

11. On [redacted], the resolution to the Local Appeal was completed by the Utilization Manager, with a decision to uphold the original request; approval of four months ACT services in order to transition to Case Management Services. Resolution states: "service (ACT0 was no longer medically necessary, that the consumer primarily benefits from the case

management function of the ACT services. In addition, the consumer is approved for psychiatric reviews."

12. A Chart note indicates, "Consumer is doing well as a result of the current intensity of supports and services provided. However, the current level of care and the current amount and frequency of services used would be available at the Case Management level. Additional peer supports or therapy could also be appropriated for assisting with the functional needs documented in the record.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…

42 USC 396n(b)

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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

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.*

CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve his/her goals.

The Medicaid Provider Manual states in pertinent part:

> **SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM**
>
> Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

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, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-daysper- week crisis availability provided by the multi-disciplinary ACT team which includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team staff.

The Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of are. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDHHS and meet the program components outlined below. Provider programs with more than one ACT team must have individually approved and registered ACT teams. All ACT teams are subject to MDHHS re-approval every three years.

4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary diagnosis of serious mental illness and who, without ACT, would require more restrictive services and/or

settings. ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality disorder or co-occurring Substance Use Disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. Areas of impairment are significant, and are considered individually for each beneficiary.

These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends;
- Accessing needed mental health and physical health care;
- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens;
- Performing activities of daily living or other life skills;
- Managing medications without ongoing support;
- Maintaining housing;
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison;
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
- Maintaining recovery to meet the challenges of a co-occurring Substance Use Disorder;
- Encountering difficulty in past or present progress toward recovery despite participation in long term and/or intensive services.

4.3 ESSENTIAL ELEMENTS

Team-Based Service Delivery

ACT is a team-based behavioral health service that includes shared service delivery responsibility that provides consistent continuity of care. Case/care management, psychiatric services, counseling/psychotherapy, peer support services, housing support, substance use disorder treatment, employment and rehabilitative services are interwoven with treatment and rehabilitative services, and services are provided by all members of the ACT team in the beneficiary's home or community.

All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-approved ACT-specific training annually thereafter.

All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners must participate in the MDHHS-approved Physicians/Nurse Practitioners training one time, with additional ACT training/participation for Physicians/Nurse Practitioners encouraged, but not mandatory. Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians and/or Nurse Practitioners are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case/care management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community.

A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed upon community location. Treatment groups identified in the Individual Plan of Service (IPOS), such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held.

The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team

members, to an individual consumer will comprise 80% of home or community contacts.

4.4 ELIGIBILITY CRITERIA

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of 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 or 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 acute service selection guideline covers criteria in the following domains:

Diagnosis: The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness

Psychiatric Status

- 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/parental role performance expectations.

- Drug/Medication Conditions - Drug/medication adherence and/or a co-existing 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 beneficiary 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

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 beneficiary to function without more restrictive care, and the beneficiary 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 beneficiary'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 in a 24-hour protective environment.
- The beneficiary 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 adherence 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

For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management. (Emphasis added)

Cessation or control of symptoms is not sufficient for discharge from ACT. For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person centered planning process as described below:

- 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 show clinical stability. (Emphasis added)
- Beneficiaries who meet medical-necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program.
- If a beneficiary requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive services 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 IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for re-enrollment into ACT services, if needed.

- Engagement of the beneficiary 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. Contact continues until service has been established in the new location.

Medicaid Provider Manual, Behavioral Health and Intellectual And Developmental Disability Supports and Services April 1, 2016, Pages 33- 35

On [redacted], [redacted] CMH notified Petitioner that the decision to reduce ACT was not an indication that no services were needed and is not a decision to close the consumer from CMH services. We encourage the consumer to transfer to a case management program and work to develop a set of services that can meet her current needs. The decision to deny is upheld. (Respondent's Exhibit A page 10)

The [redacted] CMH representative testified on the record that Petitioner is receiving ACT services which is the most intensive level of services before Adult Residential Care. Petitioner was receiving 32 units per month of ACT services. She was using an average of 20 units per month of ACT services from [redacted]. Petitioner was only using and average of 16 units per month of ACT services from [redacted]. Petitioner was underutilizing the ACT services and mostly using case management type services so she was offered the case management option and 20 units of Community Living supports effective [redacted] because she wasn't using the full intensity of ACT services and thus, does not meet medical necessity.

Medicaid Policy explicitly dictates that: For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management.

This Administrative Law Judge finds that [redacted] CMH has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Petitioner's ACT case

should be cancelled effective [redacted], because it has been shown that Petitioner has progressed forward on her journey towards recovery and is ready for less intensive service, such as case/case management, in conjunction with other approved services which will be sufficient in amount, scope and duration to meet Petitioner's medically necessary needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] CMH properly proposed to cancel Petitioner's ACT services under the circumstances and replace them with case management services and 20 units of Community Living Supports.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.

LL/[redacted]

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Petitioner [redacted]

Agency Representative [redacted]

DHHS -Dept Contact [redacted]

DHHS Department Rep. [redacted]