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. 2009-28240 CMH
Case No. [redacted]

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] appeared on his own behalf. [redacted], was present on behalf of the Appellant. [redacted], appeared on behalf of [redacted]; and [redacted] appeared as witnesses for the [redacted].

ISSUE

Did [redacted] (CMH) properly authorize respite hours for 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. The Appellant is a Medicaid beneficiary receiving services through [redacted] as an adult with a Developmental Disability. He is not enrolled in the Habilitation and Supports Waver Program.

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. The Appellant is a [redacted] Medicaid beneficiary. The Appellant has the Charcot-Marie Toothe form of muscular dystrophy. (Exhibit 1 Page 2).

4. Appellant is his own guardian but needs personal care services due to his muscular dystrophy. (Exhibit 1 Page 12).

5. The Appellant lives with his father and stepmother in an unlicensed setting.

6. Appellant's father is his primary caregiver. Appellant's father receives payment from the Department of Human Services Home Help Services program for Appellant's personal care.

7. The Appellant has been receiving respite services from CMH. (Exhibit 1 Page 5).

8. On [redacted], CMH scored Appellant's need for respite services as "high." (Exhibit 1 Page 5).

9. Appellant's [redacted] Individualized Plan of Service (IPOS) authorized [redacted] units of respite.

10. At some time after [redacted] CMH reviewed its approval practices for respite and in order to be in compliance with Medicaid policy, no longer authorized personal care as part of respite for individuals living in unlicensed settings.

11. As a result of the CMH change in application of Medicaid policy, the Appellant's [redacted], respite assessment was "medium." (Exhibit 1 Page 4).

12. Appellant's [redacted] Individualized Plan of Service (IPOS) authorized [redacted] fifteen minute units for respite, a reduction from the previous year. (Exhibit 1 Page 12).

13. Appellant's [redacted] IPOS included a notice of hearing rights. (Exhibit 1 Page 16).

14. The Appellant's request for hearing was received by this office 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) 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 CMH representative and witness [redacted] stated during the hearing that approximately one year ago [redacted] reviewed authorization for respite and personal care. The CMH representative explained that Medicaid policy does not pay for personal care in an unlicensed setting because it is available for unlicensed settings through the state plan service offered by the Department of Human Services. The CMH further explained that it had included personal care units for the [redacted] authorization of respite but when it realized that it was out of compliance with Medicaid policy it had to remove the personal care amount from the

authorization. CMH witness [redacted] testified that the Appellant's IPOS reflected a reduction in respite unit authorization because the personal care aspects had to be removed.

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard to respite and personal care:

> **17.3.J. RESPITE CARE SERVICES**
>
> Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary care giver. Decisions about the methods and amounts of respite should be decided during person-centered planning.
>
> PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.
>
> (Underline emphasis added by ALJ).
>
> *July 1, 2009, Pages 110 and 111.*

> **SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS**
>
> Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by DHS.
>
> Personal care services are covered when authorized by a physician or the case manager or supports coordinator, in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.
>
> **11.1 SERVICES**
>
> Personal care services include assisting the beneficiary to perform the following:
> - Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
> - Eating/feeding;
> - Toileting;
> - Bathing;

- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed and certified by the state under the 1987 Department of Mental Health Administrative Rule R330.1801-09 (as amended in 1995). (Underline emphasis added by ALJ).

July 1, 2009, Page 60.

During the hearing the Appellant testified that he has muscular dystrophy, his condition is degenerative and his father is his primary caregiver. The Appellant asserted that the care from his father was medically necessary and it was not fair that the respite hours were reduced.

It is noted that the Appellant's reduction in respite authorization from [redacted] to [redacted] was not related to medical necessity; rather it resulted as a correction in the misapplication of policy in [redacted]. The CMH representative and CMH witness testified that to properly authorize CMH respite services it must follow the state Medicaid policy. It was proper for CMH to remove personal care from the respite authorization because it cannot authorize Medicaid funds for a service that is not a Medicaid covered service.

This Administrative Law Judge commends the Appellant for his zeal for independent living and the Appellant's father for his care of the Appellant. However, the CMH must authorize respite services in accordance to the CFR and state policy. The CMH provided sufficient evidence that it adhered to the CFR and state policy when authorizing respite at [redacted] units of fifteen minutes for the Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized respite at [redacted] units of fifteen minutes for the Appellant.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

_____

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/16/2009

***** 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.