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) 334-9505

IN THE MATTER OF:

Docket No. 2012-40877 CMH

Appellant
______________________/

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 Appellant's mother, appeared and testified on behalf of the Appellant.

, Due Process Manager, appeared on behalf of County Community Mental Health (CMH or Department). , Manager, Utilization Management Department, appeared as a witness for the Department.

ISSUE

Did CMH properly determine Appellant's respite hours?

FINDINGS OF FACT

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

1. As of , the Appellant is no longer enrolled in Medicaid. (Exhibit 1, Testimony)

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to Medicaid eligible people who reside in the CMH service area.

3. When CMH completed a respite assessment for Appellant on , Appellant was enrolled in Medicaid under a deductible, but had not yet met that deductible, so her Medicaid coverage was inactive. (Exhibit 2, Testimony)

4. CMH further determined that Appellant had not met her Medicaid deductible for several months, so Appellant's Medicaid coverage had been inactive for several months. (Exhibit 1, Testimony).

5. On [redacted], Appellant's mother requested [redacted] respite hours per month. CMH conducted a Respite Assessment. As a result of the Assessment, Appellant was approved for [redacted] hours of respite per month. (Exhibit 2, pp 4-8).

6. On [redacted] CMH sent an Adequate Action Notice to the Appellant notifying her that the request for 70 respite hours per month was denied, but that 23 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 2, pp 1-3).

7. During the preparation for the hearing, CMH noted that Appellant was no longer enrolled in Medicaid and on [redacted], CMH sent Appellant an Advance Action Notice informing Appellant that services were being terminated because Appellant was no longer enrolled in Medicaid. (Exhibit 2, pp 9-11)

8. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 3).

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.*

CMH witness [redacted] testified that as of [redacted] Appellant was no longer enrolled in Medicaid. [redacted] further pointed out that at the time of the Respite Assessment, Appellant was enrolled in Medicaid under a deductible but, because she had not met that deductible, her Medicaid coverage was inactive. [redacted] also pointed out that Appellant's Medicaid coverage had been inactive for several months because of her failure to meet her Medicaid deductible.

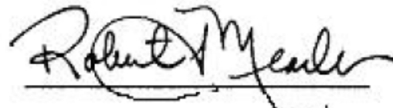
[redacted], Appellant's mother, confirmed that her daughter is currently not enrolled in Medicaid. [redacted] was informed that should her daughter become eligible for Medicaid in the future, she could again request respite hours and, should her request be denied, she would have the right to a Medicaid Fair Hearing.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant is not currently enrolled in Medicaid and her Medicaid coverage was inactive at the time of her last respite assessment.

IT IS THEREFORE ORDERED that:

> The CMH decision to terminate Appellant's services because she is no longer enrolled in Medicaid is AFFIRMED.



Robert J. Meade
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 5-4-12

***** 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.