STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
ADMINISTRATIVE TRIBUNAL
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IN THE MATTER OF:

Sullivan, John,

Appellant
_____/

Docket No. 01-0358CMH
01-2388CMH
Case No. V2118594A
Load No. 76000205

POLICY HEARING AUTHORITY DECISION

This case is being decided by the Policy Hearing Authority pursuant to a delegation of authority dated December 4, 2001. The original hearing in this matter was held on March 23, 2001 and June 7, 2001. The Recommended Decision was issued on February 12, 2002.

The recommended decision issued by the Administrative Law Judge has been read and considered, together with the evidence in the record. Exceptions were filed and considered.

After review of the record and the Recommended Decision, it is my decision that:

> The Administrative Law Judge's findings of fact in his recommended decision are adopted as my findings of fact.

The following are my Conclusions of Law:

Issues 1 and 2

Issue 1: Are Alternative Services found in the Community Health Services Program manual at pages 18- 22 and pages 55-61 Medicaid Covered Services?

Issue 2: Does the Administrative Tribunal have jurisdiction to consider issues related to "alternative services"?

42 USC 1396d lists the services which constitute "medical assistance" under the Act and defines each service. Michigan's State Medicaid Plan (State Plan) identifies the specific "medical assistance" services that it chooses to provide to eligible individuals who reside in Michigan.

States may request a waiver of certain statutory provisions from the Secretary of Health and Human Services. The specific types of waivers allowed are found at 42 USC 1396n. (The waivers under this provision are commonly referred to as 1915b or 1915c waivers.)

Waivers may be granted that promote cost-effectiveness, efficiency and flexibility (1915 b and 42 CFR 430.25(c)(1)). The Michigan Department of Community Health (MDCH) applied for and received approval of a waiver under section 1915b(1) and (4) for specialty supports mental health services. The services defined in the waiver document are State Plan services and therefore Medicaid covered services. They must be provided: (1) to any eligible individual (2) who has been determined to have a medical necessity for the service (3) in the appropriate scope, duration and intensity.

MDCH did not apply for a 1915b(3) waiver (42 USC 1396n(b)(3)) which would allow the provision of additional services for medical assistance recipients "under the State Plan" through the use of cost savings. The waiver preprint instructions for 1915b(3) state:

> The State will share costs savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid recipient. Please list additional services to be provided under the waiver which are not covered under the State Plan in section A. III.d.1.and Appendix D.III. The services must be for medical or health related care or other services as described in 42 CFR Part 440 and are subject to HCFA approval.

If the State had applied for and received approval for a waiver under this subsection, the additional services would have required approval by Centers for Medicaid and Medicare Services (CMS) and would have been considered as new services under the State Plan and therefore, Medicaid covered services. The waiver preprint document identifies "Medicaid services (emphasis added) the MCO/PHP will be responsible for...the purpose of the chart is to show which of the services in the State's State Plan are/are not in the MCO/PHP contract; ...which are new services available only through the MCO/PHP under a 1915(b)(3) waiver." The alternative services identified on Attachment A of the waiver are not included in the list of Medicaid covered services identified in the required chart in the waiver document.

Section 1915(a)(1)(A) of the Social Security Act (42 USC 1396n(a)(1)(A)) allows a State to contract with an organization which has agreed to provide care and services in addition to those offered under the State Plan to individuals eligible for medical assistance who reside in the geographic service area. States are not deemed out of compliance with the Social Security Act if they choose to enter into contracts as allowed by this provision. Unlike waivers at 1915 (b) (c) and (d), this section of the Act does not require affirmative waiver approval by CMS.

Since "alternative services" are services provided under contract and are not Medicaid covered services, the Administrative Tribunal does not have jurisdiction to consider matters pertaining to "alternative services".

The "alternative services" listed In Chapter III of the Community Mental Health Services Program Manual at pages are not "Medicaid covered services".

Issues 3 & 4:

Issue 3: May Home and Community based waiver services (1915(c)) duplicate State Plan services?

Issue 4: What is the maximum allowable rate for personal care services?

1915 (c) (42 USC 1396n (c)) allows home and community based services to be classified as "medical assistance" under the State Plan when furnished to recipients who would otherwise need inpatient care that is furnished in a hospital SNF, ICF or ICF/MR and is reimbursable under the State Plan. (42 CFR 430.25(b))

> Home and community based services means services not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. (42 CFR 440.180(a))
>
> Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by HCFA:
>
> (1) Case management services.
> (2) Homemaker services.
> (3) Home health aide services.
> (4) Personal care services.
> (5) Adult day health services
> (6) Habilitation services.
> (7) Respite case services.
> (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a

facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

(9) Other services requested by the agency and approved by HCFA as cost effective and necessary to avoid institutionalization. (42 CFR 440.180(b)

The federal regulations define home and community based services as services, not otherwise furnished under the State's Medicaid plan. *(emphasis added)*

The State of Michigan has chosen to provide Personal Care Services to eligible recipients as part of its State Plan. These services are also called Home Help services. Personal Care Services include: assistance with activities of daily living including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring) and instrumental activities of daily living including personal laundry, light housekeeping, shopping and errands, meal planning and preparation and self administration of medication. Michigan has further chosen to provide transportation as a State Plan service available to any eligible Medicaid recipient for medically related purposes as defined by policy.

Department of Community Health policy, Community Mental Health Services Programs (CMHSP) manual, Chapter III, page 63, lists as 1915(c) waiver services: meal preparation, laundry, routine household care and maintenance, assistance with activities of daily living such as bath, eating dressing personal hygiene, shopping, and transportation. Each of these services is also provided through the State Plan. The Family Independence Agency (FIA) has also been designated as the agency to provide State Plan services to eligible recipients for transportation to obtain medical evidence or to receive a Medicaid covered service from any MA-enrolled provider. (See PAM 825)

The Department may not duplicate any services provided in the State Plan with services provided under a Home and Community Based Waiver.

The Family Independence Agency is the Department of Community Health's designated agency for the provision of the State Plan service, Personal Care, also known as Home Help Services. Department policy in the Adult Services Manual defines the procedures and policies regarding these services. The Personal Care hourly rate is established by the local FIA office director pursuant to MAC R 400.1101 et. seq. The Personal Care policy further provides for the consideration of a payment amount over the standard rate for the provision of Home Help Services. Medical necessity, appropriate scope, duration and intensity are assessed and authorized by the FIA.

The Family Independence Agency sets rates paid to providers of personal care/home help services. Policy provides for individual needs that exceed the hourly rate. That is the total amount that may be paid.

Issue 5: May room and board be considered an "alternative service"?

The Social Security Act and its regulations routinely exclude room and board as a Medicaid service for which federal financial participation is available. Examples of such exclusions are found at 42 USC 1396n(c) and 42 CFR 441.310 for Home and Community Based Waiver services and as a Community Living Supports service at 42 USC 1396u(f). Federal financial participation for room and board is only allowed in specific situations such as inpatient hospital and nursing facilities. Categories of "medical assistance" for which payment will be made are listed in 42 USC 1396d. Room and board is not one of the listed services.

The Department has, in its CMHSP manual, alternative services for individuals with developmental disabilities and serious mental illness. These services are additional services to the State Plan and provided under provision of contract. (1915(a)(1)(A)) Although "housing assistance" is defined differently for individuals with mental illness and individuals with developmental disabilities, "housing assistance" is allowed as an alternative service. (See CMHSP manual pages 20 and 58.)

Room and board is not an allowable "alternative service".

Issue 6: Does the Administrative Tribunal have jurisdiction to hear disputes between a provider and a CMHSP regarding payment methodology?

The Administrative Tribunal does not have jurisdiction to hear disputes between a provider and the CMHSP regarding payment methodology. This dispute is a contractual one between the provider and the CMHSP. The CMHSP is paid a capitated amount to provide covered services to eligible recipients. The CMHSP has the authority to decide the payment process for services. This process is not within the jurisdiction of the Tribunal.

If the Medicaid recipient has not been provided medically necessary services, for whatever reason, the Administrative Tribunal has jurisdiction to hear that case. This jurisdiction is a result of a Medicaid covered service being reduced, terminated, suspended or denied. The Administrative Tribunal would have authority to order the CMHSP to provide medically necessary services in the appropriate scope, duration and intensity.

ORDER

The Policy Hearing Authority, based upon the Findings of Fact and Conclusions of Law set forth above, orders that:

Issues 1 & 2

IT IS THEREFORE ORDERED that the Department rewrite Chapter III, pages 55-61 and pages 18-22 and remove all alternative services to make clear that the alternative services are not Medicaid covered services.

IT IS FURTHER ORDERED that the contracts between the MDCH and the various CMHSP be modified to clearly delineate all of the alternative services that the various CMHSPs may elect to provide and that recipients may accept to receive; that they are alternative services; and they are not Medicaid covered services; and these services may be paid from capitation funds.

IT IS FURTHER ORDERED that since the provision or denial of alternative services are not Medicaid covered services that the Administrative Tribunal does not have jurisdiction to hear matters pertaining to the denial of "alternative services".

IT IS FURTHER ORDERED that Department policy be clarified to require that each plan of service contain the date any authorized service is to be provided, the specific scope, duration and intensity of each authorized service.

Issues 3 & 4

IT IS FURTHER ORDERED that the Department amend Department policy, CMHSP Manual, Chapter III, and its Home and Community Based waiver to exclude State Plan personal care services.

IT IS FURTHER ORDERED that the maximum allowable rates for home help or personal care services as defined by the Medicaid State Plan and the Adult Services Manual are those established by the FIA local director and the exception process.

Issue 5

IT IS FURTHER ORDERED that the Department define "room and board" and exclude it as an "alternative service" in the CMHSP policy manual.

Issue 6

IT IS FURTHER ORDERED that the Administrative Tribunal does not have jurisdiction to hear disputes between the CMHSP's and providers regarding payments.

James K. Haveman, Jr., Director
Michigan Department of Community Health

cc: John Sullivan
Patricia Dudek
Craig W. Lange
Roger Dean, Ph.D.
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Date Mailed: 5·31·02