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

Docket No. 2010-23457 CMH
Case No.

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 father, , appeared on behalf of the Appellant. The Appellant was present.

represented the Department's agent or CMH). , appeared as a witness for the Department/CMH.

ISSUE

Did the CMH properly terminate the Appellant's CLS 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. The Appellant is a year-old Medicaid beneficiary.
2. is a Community Mental Health Services Program (CMH), an affiliate of the PIHP.
3. CMH is responsible for providing Medicaid-covered services to eligible recipients in its service area.
4. The Appellant is enrolled in CMH, as a person with a developmental disability. (Exhibit A).

5. The Appellant's Person-Centered Plan (PCP or IPOS) authorized 40 hours per week CLS services. The CLS services were provided through including transportation to community programs. (Exhibit A).

6. In , terminated the contract it had with CMH to provide services to CMH clients in the CMH area.

7. In CMH initiated a PCP planning process for Appellant, and indicated it would only provide) hours per week (instead of the prior 40 hours per week) of CLS to Appellant. (Exhibit 2, p. 3 of 6). The CMH informed Appellant the hours per week CLS services authorization would no longer include transportation. (Exhibit 2, p. 3 of 6).

8. In or after the CMH stopped providing CLS services and stopped providing transportation to CLS programs. (Testimony of Appellant's father).

9. In or around the beginning of CMH sent the Appellant written notice that his CLS services would be terminated. (Exhibit 1).

10. Appellant's CLS services were terminated because the CMH did not have sufficient providers under contract to provide CLS to its clients. (Testimony-various).

11. The CMH informed Appellant he must enter into self-determination and find his own CLS provider, including find his own CLS-transportation or have his parents drive him. (Testimony of CMH representative and Appellant's father).

12. The Appellant's request for hearing was received by this State Office of Administrative Hearings and Rules for the Department of Community Health on (Exhibit A).

13. Subsequent to the notice of CLS termination the CMH told Appellant that it made an error by using the term "termination" in its notice, instead, it would provide the per week CLS only if Appellant's parents could find a provider and only if Appellant's parents could drive Appellant to the provider. (Testimony of CMH representative).

14. Subsequent to the notice of CLS termination, the CMH assisted Appellant into a three (3) times per week program, but refused to pay for transportation to the program, instead informing Appellant's parents they needed to provide their son's transportation.

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) 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 only entitled to medically necessary Medicaid covered services. 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*. CLS is a Medicaid covered service available through CMH. See *Medicaid Provider Manual, Mental Health and Substance Abuse Section, Section 17.3.B, January 1, 2010, p. 100*).

Medicaid Provider Manual, *Mental Health and Substance Abuse Chapter, January 1, 2010, p. 13,* defines medical necessity and the criteria used to determine medical necessity for a Medicaid-covered service:

> **2.5.B Determination Criteria**
>
> The determination of a medically necessary support, service or treatment must be:
>
> … For persons with…developmental disabilities, based on person-centered planning…

The parties stipulated that Appellant's [redacted] PCP authorized CMH to provide at least [redacted] hours per week CLS services to Appellant.

The CMH representative stated that although CMH sent written notice to Appellant informing him his CLS would be terminated, it did not terminate Appellant's CLS, rather merely suspended the services until Appellant found his own CLS provider. The CMH representative testified that the CMH had no CLS provider or CLS-transportation provider so for convenience it was moving Appellant into self-determination for CLS and CLS transportation. The CMH representative explained that it did not terminate the Appellant's CLS services because it now that it had moved the Appellant into self-determination it was his responsibility to find a CLS provider and as the Appellant had not found a CLS provider it was not CMH obligation to cover those services. The CMH representative elaborated that the Appellant was switched by CMH into self-determination for CLS authorization only and CMH let him remain outside of self-determination for any other CMH authorized service.

Any termination of a Medicaid-covered CMH authorized service triggers a right to fair hearing, a right to an CMH-issued advance action notice, and a right to request the

service be continued during appeal, prior to termination of service. The federal regulation related to actions which trigger Medicaid fair hearing:

> 42 CFR 438.400.
>
> (a) (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
>
> (b) Action means-- In the case of an MCO or PIHP--
>
> (2) The reduction, suspension, or termination of a previously authorized service.

The Appellant's father competently testified that he and Appellant did not know what self-determination was, did not ask for self-determination and did not want self-determination. The Appellant's father testified that after he received the CMH's notice of termination he requested from CMH that it place in writing the authority for forcing Appellant into self-determination against his will, Appellant's obligations under self-determination, and the authority under which Appellant had to find his own CLS and CLS-transportation – but the CMH never provided the requested information.

This Administrative Law Judge finds that the CMH attempted to force Appellant into a self-determination type arrangement against his will to avoid its own responsibility to provide services it had authorized. There is no Department policy that gives CMH authority to force a Medicaid beneficiary into self-determination. There is no Department policy that relieves CMH of its contractual obligations with the Department to provide services to CMH enrolled Medicaid beneficiaries or relieves CMH of its obligations to provide services it authorized in Appellant's person-centered plan.

The credible evidence shows that after CMH lost its contract with the CLS provider it stopped providing all CLS services to Appellant. The clear and undisputed evidence in this matter demonstrates that CMH terminated Appellant's CLS and CLS-transportation services; services which it is obligated to provide with its authorization of CLS for Appellant.

With regard to CLS-transportation, Medicaid Provider Manual, Mental Health and Substance Abuse Services, Section 17.3.B, October 1, 2010, page 100, in effect at the time CMH terminated Appellant's CLS transportation, unequivocally requires transportation be provided by CMH as part of CLS:

> - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence.

It is indisputable that CLS-transportation is CMH's obligation and the CMH violated Department policy when it notified Appellant he was responsible for his own transportation to CLS programs.

With regard to provider networks the CMH representative stated that it no longer had a contract with CLS providers and it was Appellant's responsibility to find a provider, not the CMH's. The CMH representative's statements are in direct contradiction to the CMH's contractual obligations with the Department to provide CLS services to CMH enrolled Medicaid beneficiaries. In other words, CMH failed to maintain an adequate provider network of CLS providers.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 09, Part II, *Section* 6.4*, page 42,* is the section of the contract between CMH and the Department (MDCH-CMH Contract) that addresses Lenawee County CMH's obligation to maintain an adequate provider network of CLS providers:

> **Provider Network Services**
>
> The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract.
>
> In this regard, the PIHP agrees to:
>
> F. Notify MDCH within seven (7) days of any changes to the composition of the provider network organizations. PIHPs shall have procedures to address changes in its network that negatively affect access to care.
>
> Changes in provider network composition that MDCH determines to negatively affect recipient access to covered services may be grounds for sanctions. (Underline added.)

At the time of Appellant's request for hearing CMH did not have an adequate provider network of CLS providers. As of the date of hearing in , the CMH did not have an adequate provider network of CLS providers.

The federal Medicaid regulation, MDCH policy and the MDCH-CMH Contract require that medical necessary, Medicaid covered services identified in Appellant's PCP, including CLS and CLS-transportation, must be provided.

The evidence in this case demonstrates that CMH is not meeting its MDCH-CMH Contract obligations. CMH's non-compliance with the MDCH-CMH Contract negatively affects Appellant's access to CLS services and is grounds for CMH to be subjected to sanctions by the Department.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH's termination of the Appellant's CLS services was not proper and is not in compliance with the MDCH-CMH Contract.

IT IS THEREFORE ORDERED that:

> The CMH decision and action, which in effect terminated Appellant's CLS services, is REVERSED.

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

cc:

Date Mailed: 05/17/2010

***** 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.