[redacted]
MI[redacted]

Date Mailed: December 15, 2023
MOAHR Docket No.: 23-006727
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone prehearing conference was held on November 8, 2023 and a telephone hearing was held on December 13, 2023. Petitioner [redacted] (Petitioner) appeared on her own behalf. Chelsea Vinson, Paralegal, represented Respondent UnitedHealthcare Community Plan (Respondent), Petitioner's Medicaid Health Plan (MHP).

During the hearing, the following witnesses appeared:

Chelsea Vinson, Paralegal

[redacted] COO

[redacted] Compliance Officer

[redacted] Human Resources Area Wide Transport

[redacted] Petitioner

[redacted] Friend

[redacted] Friend

[redacted] Son

The following exhibits were also entered into the record without objection:

Exhibit #1: Petitioner's Evidence Packet, pages 1-65

Exhibit A: Respondent's Updated Evidence Packet, pages 1-105

ISSUE

Did Respondent properly authorize and provide non-emergency medical transportation (NEMT) to Petitioner?

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 Medicaid beneficiary enrolled with Respondent. (Exhibit A, p 1).

2. She is also enrolled in Respondent's Medicare Plan. (Exhibit A, p 2).

3. Petitioner has significant medical needs, and she requires NEMT to see her medical providers and obtain prescriptions as she cannot drive herself, has no one to drive her, and cannot use public transportation. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

4. As part of her transportation needs, Petitioner must have a wheelchair-accessible vehicle. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

5. She has also reported a need for a female driver. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

6. Respondent provides NEMT to its beneficiaries through Modivcare, a transit broker who in turn contracts with vendors who provide the actual services. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

7. For various reasons discussed more thoroughly in the prior case, Respondent has been unable to find a suitable transportation provider for Petitioner. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

8. With no vendors able or willing to meet Petitioner's NEMT needs, Respondent notified Petitioner that her NEMT would be limited to mileage reimbursement. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*).

9. On August 31, 2023, ALJ Kibit issued a Decision and Order in which he reversed Respondent's decision in part, concluding:

> Accordingly, given the undisputed medically necessary services . . . ., the undersigned ALJ finds that Respondent erred in limiting Petitioner's NEMT to

> gas mileage reimbursement only and its decision to do so must be reversed.
>
> ****
>
> The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent improperly limited Petitioner's NEMT to gas mileage reimbursement only. (*See Decision and Order, dated August 31, 2023, docket no. 23-002925*.)

10. On October 16, 2023, MOAHR received Petitioner's request for hearing in which she indicated that Respondent still had not found a transportation provider for her and was, therefore, in violation of the previous ALJ's Order. (Exhibit 1).

11. A telephone prehearing conference was held on November 8, 2023 in which this ALJ informed the parties that while Respondent's continued failure to find a suitable transportation provider for Petitioner constituted a negative action giving rise to the right to a Medicaid fair hearing, all this ALJ could do was continue to Order Respondent to keep trying. (*See Prehearing Conference Summary and Order and Notice of Hearing, dated November 8, 2023*).

12. Respondent has taken some steps to try to find a suitable transportation provider for Petitioner since the last hearing, but as of the date of this hearing, Respondent had still not found such a provider. (Exhibit A, pp 101-105.)

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.

In 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those MHPs and, as provided in the Medicaid Provider Manual (MPM) in effect at the time of the services at issue in this case, is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

* * *

- Medically necessary transportation for enrollees without other transportation options

* * *

- Transportation for medically necessary covered services

MPM, October 1, 2023 version
Medicaid Health Plan Chapter, page 1

Moreover, with respect to the covered transportation, the MPM further states in part:

SECTION 1 – INTRODUCTION

This chapter applies to non-emergency medical transportation (NEMT) providers and authorizing parties. The Medicaid NEMT benefit is covered for Medicaid, MIChild, and Healthy Michigan Plan (HMP) beneficiaries, and for Children's Special Health Care Services (CSHCS) beneficiaries who also have Medicaid coverage.

Federal law at 42 CFR 431.53 requires Medicaid to ensure necessary transportation for beneficiaries to and from services that Medicaid covers. The NEMT benefit must be administered to beneficiaries in an equitable and consistent manner.

Beneficiaries are assured free choice in selecting a Medicaid medical provider to render services. A beneficiary's free choice of medical provider selection does not require the Medicaid program to cover transportation beyond the standards of coverage described in this policy in order to meet a beneficiary's personal choice of medical provider.

Forms referenced in this chapter are accessed via the beneficiary's case worker and are maintained on MI Bridges.

* * *

SECTION 2 – COMMON TERMS

Authorizing Party	An affiliated entity of the Medicaid program (e.g., local MDHHS office or Medicaid-contracted transportation broker) responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.

* * *

SECTION 3 – TRANSPORTATION AUTHORIZATION

Medicaid authorizes fee-for-service (FFS) NEMT services via local MDHHS offices, except in Wayne, Oakland, and Macomb counties. FFS transportation services in Wayne, Oakland, and Macomb counties are administered through a contracted transportation broker. (Refer to the Directory Appendix for transportation broker information.)

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

* * *

SECTION 5 – COVERED SERVICES

NEMT expenses, regardless of whether there is a corresponding medical claim on the date of service, may be covered for trips to and from:

- Treatment Medicaid covers (one-time or ongoing);
- Ancillary service providers (e.g., pharmacies, durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] providers) to obtain a service or item Medicaid covers;
- Medical care, treatment or services that have been prior authorized;
- Appointments to obtain medical evidence (for eligibility verification purposes only); and
- Facilities providing services Medicaid covers that do not charge for care.

Transportation from a service Medicaid covers is only covered when it is from the provider's location to the beneficiary's residence or to another service Medicaid covers. The least costly mode of transportation appropriate for the beneficiary's medical needs must be used. Medicaid authorizes and reimburses transportation providers directly for the following NEMT services:

- Long-term lodging for approved transplant hospitals.
- Transportation to and from pregnancy-related services for Medicaid beneficiaries enrolled in the Maternity Outpatient Medical Services (MOMS) program.
- Transportation to and from day treatment provided by a Community Mental Health Services Program (CMHSP) (as part of its treatment package) for children enrolled in the Children's Waiver Program (CWP).

Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party to receive reimbursement. Medicaid FFS authorizing parties may accept the submission of a complete MSA-4674 form and receipts via fax and secure email. Transportation providers and beneficiaries may submit original forms and receipts if they choose, but sending original forms and receipts is not required for reimbursement. Providers and beneficiaries are encouraged to keep an original or copy of forms and receipts submitted to MDHHS for reimbursement.

NEMT reimbursement must reflect the total incurred cost to the transportation provider(s) and to the beneficiary, and must be verified with itemized, unaltered receipts. All receipts must be legible and included with the MSA-4674. Transportation providers must be enrolled in CHAMPS on the date of service to receive Medicaid NEMT reimbursement unless the provider is exempt from enrollment.

In order to assure appropriate reimbursement for NEMT, MDHHS maintains a database of provider rates which is available on the MDHHS website. The database is reviewed and updated as applicable. (Refer to the Directory Appendix for website information.) NEMT providers must bill MDHHS the usual and customary fee charged to the public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced

charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.

5.1 MILEAGE

The Medicaid program covers the least-costly available mode of transportation suitable to the beneficiary's medical condition. The following modes of transportation are commonly utilized:

- Commercial and nonprofit transportation
- Fixed route, demand response and deviated route public transportation
- Volunteer drivers
- Individuals with a vested interest
- Beneficiaries providing their own NEMT in their personal vehicle

Volunteer drivers will not be reimbursed for driving a vehicle owned by the beneficiary or a member of the beneficiary's family.

When available, medical providers or entities that offer transportation or medical delivery services at no charge (e.g., prescription delivery services offered by the beneficiary's pharmacy) should be utilized.

Mileage is reimbursed according to transportation provider type at the appropriate rate as indicated on the MDHHS NEMT Database. Total round-trip mileage must be rounded up to the nearest mile and must be verifiable using an online mapping service or a Global Positioning System device.

* * *

5.5 SPECIAL ALLOWANCES

Special allowances (i.e., wheelchair lift-equipped or Medi-Van vehicles, or medically necessary attendants) are

reimbursed at the rate listed on the MDHHS NEMT Database. The beneficiary's physician must document the medical necessity of all special allowances on the DHS-5330.

* * *

SECTION 6 – MANAGED CARE PROGRAMS

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to beneficiaries. These entities are responsible for providing NEMT services to their enrollees for all services covered under their contract. (For additional information, refer to the Medicaid Health Plans and the MI Health Link chapters of this manual.)

For services provided to managed care enrollees in an FQHC, the MHP covers NEMT when:

- the service is covered under the MHP contract and the FQHC is in the MHP's provider network; or
- the MHP has prior authorized the FQHC for the service.

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP or ICO for further information regarding NEMT for their beneficiary. Transportation services for these enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

MPM, October 1, 2023 version
NEMT Chapter, pages 1-2, 4, 9-11, 13

Respondent reviewed its Hearing Summary (Exhibit A) and highlighted the steps it has taken since the last hearing to find suitable transportation for Petitioner. Respondent also highlighted issues it believes led to some providers excluding Petitioner.

Petitioner reviewed her medical conditions and the reasons why she needs NEMT, and why she cannot use NEMT limited to mileage reimbursement only. Petitioner also raised a number of grievances she has had with Respondent, Modivcare, and particular drivers in the past.

Petitioner was informed at the prehearing conference that complaints about how approved services are provided, or the quality of those services, is not something that can be resolved at a Medicaid fair hearing. Such complaints must go through Respondent's grievance process, which Petitioner is familiar with because she has used it before. (*See* 42 CFR 438.400(b)[1]).

Also, as the parties were informed prior to the hearing, ALJ Kibit has already determined that NEMT limited to mileage reimbursement only does not meet Petitioner's needs, so that issue does not need to be relitigated.

Further, as the parties were informed by ALJ Kibit and by this ALJ, this tribunal has no authority to order Respondent to use any particular transportation provider. The Code of Federal Regulations (CFR) affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *42 CFR 438.400.* Here, there is a constructive denial of Petitioner's transportation services, but federal regulations only allow this tribunal to determine whether a denial was proper, not how to remedy an improper action.[2] And because this is a constructive denial as opposed to an affirmative or actual denial of Petitioner's NEMT,[3] it is irrelevant in this tribunal why or how certain transportation providers have refused to transport Petitioner, why Petitioner has refused to allow certain transportation providers, and why Respondent has discontinued its contract with a certain transportation provider. In other words, if this ALJ cannot order Respondent to use a particular provider, the reasons why any of those providers are currently unavailable to Petitioner is irrelevant. And again, issues regarding how approved transportation services are provided, or the quality of those services, is a matter for Respondent's grievance process, not a Medicaid fair hearing.

This ALJ can, however, order Respondent to continue to try to find a suitable transportation provider for Petitioner. As this ALJ also informed the parties earlier, under the circumstances, the only way Respondent can accomplish this task is if the parties work together. Understandably, this will be difficult given past situations, but there is no other way for Petitioner to achieve her desired result. This ALJ would suggest that it might be necessary for the parties to revisit some of the transportation providers that have excluded Petitioner, or the ones Petitioner has excluded, to see if an accommodation can be made.

However, given that Petitioner is still being constructively denied transportation services that meet her needs, Respondent's decision must be reversed.

---

[1] Grievance "means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision." Emphasis added.

[2] *Id*.

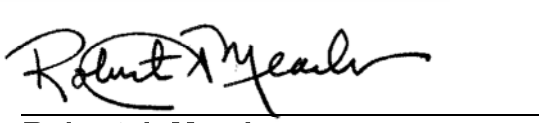
[3] All of Petitioner's transportation requests have been approved by Respondent.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent improperly limited Petitioner's NEMT to gas mileage reimbursement only.

IT IS, s, ORDERED that:

Respondent's decision is **REVERSED**, and it must continue to search for a transportation provider that can meet Petitioner's needs.



RM/sj

Robert J. Meade
Administrative Law Judge

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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 15th day of December 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

Community Health Representative
United Healthcare Community Plan
3000 Town Center
Southfield, MI 48075
Chelsea_vinson@uhc.com

DHHS Department Contact
MDHHS Managed Care Plan Division
Lansing, MI 48933
MDHHS-MCPD@michigan.gov

Via First Class Mail:

Petitioner
[redacted]
[redacted] MI [redacted]