TERMINATION BY PROVIDERS OF MENTAL RETARDATION SERVICES

This Fact Sheet addresses the standards and procedures that govern a provider's decision to terminate mental retardation services. It is important to ascertain whether the services are funded through a Medical Assistance Waiver or, instead, are funded by state/county mental retardation dollars (called "base-funded") because there are significant differences in the standards and procedures.

I. Termination of Waiver Services

Under Medical Assistance, a provider cannot be forced to provide services to a recipient. The provider must be "willing." As a result, the provider can terminate services for any number of reasons. However, it is possible that the Individual Service Plan (ISP) specifies a particular provider, in which case the termination of an individual from service by a particular provider might be deemed a violation of the ISP. Even then, the ISP lasts only a year so the provider would not be bound to continue services beyond the end of the ISP.

While the provider may choose to terminate a person from service, DPW and the County have obligations under federal law to provide necessary services identified in the individual's ISP. The federal Medical Assistance statute provides that home and community-based waiver services are "medical assistance" services to which eligible persons are entitled. 42 U.S.C. § 1396n(c). Pennsylvania provided certain assurances to the Center for Medicare and Medical Assistance Services (CMS) as a condition to receipt of its Waivers. 42 U.S.C. § 1396n(c)(2); 42 C.F.R. §§ 441.302, 441.303. Among other things, Pennsylvania assured: (1) that individuals eligible for services under the Consolidated Waiver will be provided with a choice between institutional and waiver services and a choice of feasible service alternatives under the waiver, and (2) that "necessary safeguards ... have been taken to protect the health and welfare of individuals provided services under the waiver ...." 42 U.S.C. §§ 1396n(c)(2)(A), 1396n(c)(2)(C). In furtherance of these provisions, the MR Waivers require that individual plans of care will be developed by qualified persons describing the services to be provided and that plans of care will be reviewed "to ensure that the services furnished are consistent with the identified needs of the individuals.

CMS has interpreted the federal Medical Assistance statute to mean that: "A State is obliged to provide all people enrolled in the waiver with an opportunity for access to all needed services covered by the waiver and the Medicaid State plan. ... The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support." HCFA, *Olmstead Update No. 4* at 6 (Jan. 10, 2001), *available at* www.cms.gov; *see also Boulet v. Cellucci*, 107 F. Supp.2d 61, 76, 77 (D. Mass. 2000). Accordingly, it is necessary for DPW to assure that the individual receives services identified as necessary in his ISP -- even if a particular provider chooses to terminate the individual from his program. The service itself cannot be terminated unless it is no longer necessary.

If an individual's Waiver services are terminated, he should receive a written notice and information about his rights to pursue mediation and/or an appeal to DPW's Bureau of Hearings and Appeals. Both the mediation and appeals process (and forms) are described in DPW's Developmental Programs Bulletin No. 00-08-05 (Apr. 10, 2008), which is available on DPW's website.

Briefly, Developmental Programs Bulletin No. 00-08-05 clarifies that an individual in a MR Waiver can appeal, among other things, a denial of a waiver-funded service of his or her choice in the individual program plan; a refusal to allow the individual to use a willing and qualified provider of his or her choice to provide the service; and any decision or action to refuse, suspend, reduce, or terminate waiver-funded services that the county or Administrative Entity has authorized; and a service of his choice. Developmental Programs Bulletin No. 00-08-05 at 4-5. DPW's regulations, too, provide that a person has the right to appeal a denial of Medical Assistance or other DPW-funded services (such as MH/MR services), including "the failure to take into account the client's choice of a service ...." 55 Pa. Code § 275.1(a)(4)(i).

A person has 30 calendar days from the date of written notice of a decision to file an administrative appeal. 55 Pa. Code § 275.3(b)(1). If the appeal is from a failure to act, the person has 60 calendar days to appeal, 55 Pa. Code § 275.3(b)(2), unless there was a duty to provide written notice in which case the person has 6 months from the date of the action or failure to act to appeal. 55 Pa. Code § 275.3(b)(3).

A person whose previously-authorized waiver services are reduced, suspended, or terminated has the right to continue to receive his or her full services pending appeal, but only if he files an appeal within 10 calendar days of being informed of the decision. 55 Pa. Code § 275.4(a)(3)(v)(C) (incorporating 55 Pa. Code § 133.4(d)(5)). This is sometimes referred to as "aid pending appeal" or the "stay put" provision. While the appeal will be considered if filed within the 30-day period described in the prior paragraph, the reduction, suspension, or termination of service will take effect if the appeal is not filed within 10 days after notice.

II. Termination of State/County-Funded MR Services

DPW's regulations under the MH/MR Act require counties to develop comprehensive treatment programs to meet individual needs and for community residential mental retardation facilities to develop and implement an ISP. 55 Pa. Code §§ 4210.21-4210.22, 6400.121-6400.130. The county therefore should assure that -- even if a provider chooses to terminate services -- that the individual's needs as identified in the ISP are met. Unlike Medicaid Waiver services, though, there is no enforceable entitlement to continue to receive MR services. Services, for example, can be terminated due to lack of funding.

An individual whose provider issues a discharge notice can appeal that decision through the county administrative process designed for appeals under Pennsylvania's Local Agency Law, 2 Pa. C.S. §§ 551-555. Each county should have established procedures that govern appeals of denials and terminations of services. *See* Developmental

Programs Bulletin No. 00-08-05 at 2-3. The individual should receive information about the appeal process at the time he receives written notice of his termination from the program. In an administrative appeal, the individual has the right to present written evidence and testimony and to cross-examine witnesses. The agency must issue a written decision explaining the basis for its decision.

Local Agency Law does not expressly allow the individual to remain in his program pending the outcome of his administrative appeal. Given the nature of the deprivation involved when a person's residential program is terminated, however, an argument could be made that the individual should not be discharged until an administrative decision on his appeal is rendered unless the reason for discharge warrants immediate removal.

If the individual is not satisfied with the outcome of the county administrative process, Local Agency Law allows him to appeal the decision to the Court of Common Pleas. 2 Pa. C.S. § 751-752; 42 Pa. C.S. § 933(a)(2).

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