**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:

[redacted]

Appellant
_____/

**Docket No.** 2009-5029 DISC
**Case No.** [redacted]
**Load No.** [redacted]

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared as Authorized Representative on behalf of his mother, [redacted] (Appellant) who also appeared and testified on her own behalf.

David Harrison, Appeals Review Officer, represented the Department of Community Health (Department). Also appearing on behalf of the Department was [redacted].

## ISSUE

Did the Department properly deny the Appellant's request for dis-enrollment for cause from Molina Healthcare?

## FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a Medicaid beneficiary, currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. On [redacted], the Department received a Special Dis-enrollment-For Cause Request from the Appellant.

3. On [redacted], the Appellant was sent notification by the Department that his request was reviewed and denied, as there was no medical information provided or access to care/services issue described that would allow for a change in health plans outside of the open enrollment period.

4. The Appellant's primary care physician for the past 30 years terminated his contract with Molina Healthcare and no longer accepts Medicaid beneficiaries enrolled with this MHP.

5. On [redacted] the Appellant filed her request for hearing.

## 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.

***42 CRR § 438.56 Disenrollment: Requirements and limitations.***

(a) *Applicability.* The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) *Disenrollment requested by the MCO, PIHP, PAHP, or PCCM.* All MCO, PIHP, PAHP, and PCCM contracts must—

(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and

(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Disenrollment requested by the enrollee.* If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a recipient may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in §438.702(a)(

The Department's CMHP/Medicaid Health Plan contract disenrollment provisions must comply with the above-cited applicable Federal regulations for Health Plan contracts created under the authority of the Medical Assistance program. Specifically, 42 CFR 434.27 provides:

Sec. 434.27 Termination of enrollment.

(a) All HMO and PHP contracts must specify—

(1) The reasons for which the HMO or PHP may terminate a recipient's enrollment;

(2) That the HMO or PHP will not terminate enrollment because of an adverse change in the recipient's health; and

(3) The methods by which the HMO or PHP will assure the agency that terminations are consistent with the reasons permitted under the contract and are not due to an adverse change in the recipient's health.

The Michigan Department of Community Health, pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with Health Plan of Michigan to provide State Medicaid Plan services to enrolled beneficiaries. The Department's contract with Health Plan of Michigan provides, in pertinent part, as follows:

**Disenrollment Requests Initiated by the Contractor.**

The Contractor may initiate special disenrollment requests to DCH based on Enrollee actions inconsistent with the Contractor membership—for example, if there is fraud, abuse of the Contractor, or intentional misconduct, or if in the opinion of the attending PCP, the Beneficiary's behavior makes is medically infeasible to safely or prudently render Covered Services to the enrollee. Special

disenrollment requests are divided into three categories:

- Violent/life threatening situations involving physical acts of violence; physical or verbal threats of violence made against the Contractor providers, staff or the public at the Contractor locations; or stalking situations.

- Fraud/misrepresentation involving alteration or theft of prescriptions misrepresentation of Contractor membership, or unauthorized use of CHCP benefits.

- Other noncompliance situations involving the failure to follow treatment plan; repeated use of non- Contractor providers: Contractor provider refusal to see the Enrollee, repeated emergency room use and other situations that impede care.

**Disenrollment for Cause Initiated by Enrollee**

The enrollee may request a disenrollment for cause from a Contractor's plan at any time during the enrollment period. Reasons cited in a request for disenrollment for cause may include poor quality care or lack of access to necessary specialty services covered under the Contract. Beneficiaries must demonstrate that adequate care is not available by providers within the Contractor's provider network. Further criteria, as necessary, will be developed by DCH. Enrollees who are granted a disenrollment for cause will be required to change enrollment to another Contractor when another Contractor is available.

The Appellant states the sole reason she wishes to dis-enroll from [redacted] is because she may no longer receive Medicaid-covered services from [redacted], a physician with whom she has treated for in excess of 30 years. The evidence presented indicates that [redacted] contract with [redacted] terminated on [redacted], and that the Appellant was transferred to a new [redacted] enrolled primary care physician. The Appellant's son echoed basically the same sentiment.

The Appellant presented no evidence that she otherwise meets criteria for dis-enrollment from a Medicaid Health Plan outside of the open enrollment period, and/or that the new provider is not capable of providing for her medical needs.

Based on a preponderance of the medical evidence presented, I conclude the Department has properly denied the Appellant's Special Dis-enrollment For Cause request.

## DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that the Department has followed established policy in denying the Appellant's for cause request to dis-enroll from Molina Healthcare at this time.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/11/2009

***** 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.