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. 2009-5571 DISC
Case No. [redacted]
Load [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.,* upon the Appellant's request for a hearing appealing the Department's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held on [redacted] The Appellant appeared without representation. He had no witnesses. [redacted], represented the Department. His witness was [redacted], MSA/MDCH.

ISSUE

Did the Department properly deny Appellant's request for special disenrollment?

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 [redacted]-year-old Medicaid Beneficiary enrolled in the [redacted] since [redacted]. (Department's Exhibit A, p. 7)

2. The Department of Community Health contracts with the MHP to provide Medicaid services to the Appellant and other enrollees.

3. On [redacted] the Department (MSA) received a request for Special Disenrollment from the enrollee/Appellant. (Department's Exhibit A, p. 10)

4. The request for disenrollment was based on the issue of specific physician access. (Department's Exhibit A, p. 10)

5. The Appellant is afflicted with chronic pain in his knees, back and neck. (See Testimony)

6. On [redacted] the request was reviewed by MSA and denied as there was no medical information or access to services issue that would permit the Appellant to change health plans outside of open enrollment. (Department's Exhibit A, pp. 4, 7 and See Testimony of [redacted])

7. On [redacted] the Appellant was advised of the denial, in writing, and was informed of his further appeal rights. (Department's Exhibit A, p. 7)

8. On [redacted] the State Office for Administrative Hearings and Rules (SOAHR) received the instant request for hearing from the Appellant. (Appellant's Exhibit #1)

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 CFR § 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)(3)

The Department's 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. Code sections [42 CFR 438.100 and 438.708] provide the mechanism(s) for enrollee protection and the potential for health plan/MCO sanction.

Those sections provide;

438.100 Enrollee rights.

(a) General rule. The State must ensure that--

1. Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

2. Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(b) Specific rights--(1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.

(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to--

(i) Receive information in accordance with Sec. 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(xii).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sec. 164.524 and 164.526.

(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

(c) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

(d) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45

CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality). [67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

438.708 Termination of an MCO or PCCM contract.

A State has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to do either of the following:

(a) Carry out the substantive terms of its contract; or

(b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

*** * ***

The Michigan Department of Community Health (MDCH), pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with [redacted] to provide State Medicaid Plan services to enrolled beneficiaries and ABW recipients.

The Department's contract provides, as follows:

Disenrollment Requests Initiated by the Contractor

(2) Special Disenrollments

The Contractor may initiate special disenrollment requests to the DCH based on enrollee actions inconsistent with Contractor membership – for example, if there is fraud, abuse of the Contractor, or other intentional misconduct; or if, the enrollee's abusive or violent behavior posses a threat to the Contractor or provider. Health Plans are responsible for members until the date of disenrollment. 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; discharge from the practices of available Contractor's network providers; repeated emergency room use for non-emergent services; and other situations that impede care.

A Contractor may not request special disenrollment based on physical or mental health status of the enrollee. If the enrollee's physical or mental health is a factor in the violence or noncompliance, the Contractor must document evidence of the Contractor's actions to assist the enrollee in correcting the problem, including appropriate physical and mental health referrals. . . . [Contract at II§-F (a), pages 29-30]

Disenrollment Requests Initiated by the Enrollee

(a) Medical Exception

The beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the Contractor at the time of enrollment. The beneficiary must submit a medical exception request to DCH.

(b) Disenrollment for Cause

The enrollee may request that the Department review a request for disenrollment for cause from a Contractor's plan at any time during the enrollment period to allow the beneficiary to enroll in another health plan. Reasons cited in a request for disenrollment for cause may include lack of access to providers or necessary specialty services covered under the Contract or concerns with quality of care. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor. (Emphasis supplied)

[Contract at II§-F 12 (a) (b), page 32]

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The Department witness, [redacted], testified that the Appellant's request for disenrollment was denied as there was no credible proof of a lack of access to care, or provider issues, quality of care or treatment for a serious medical issue by physicians who do not participate in the Appellant/Enrollee's current health plan. [redacted] advised further that there was no time or distance issue and that there was no evidence that the Appellant tried to work with the MHP. She added that the [redacted] has many physicians who specialize in pain management. See Department's Exhibit A, pp. 11-14.

[redacted] further explained that the MHP was required under its contract with the State of Michigan to provide specialty care either in network or out of network.

The Appellant testified that he needs shots in his back every two months and that he feels "confined like a prisoner" and desires to be enrolled in a health plan that his long time physican [redacted] accepts – such as [redacted]

Clearly, the Appellant has a medical condition. However, the Appellant also has the burden of proof to establish some effort to work with the MHP in the procuring of appropriate medical services to treat his affliction.

Provision of those services is a matter of contractual agreement between all of the health plans and the State of Michigan. The credible testimony of Department witness [redacted] accurately described the multi-level services still available to the Appellant through his existing MHP either in network or out of network. Furthermore, she added that the Appellant is free to exercise his transfer rights on open enrollment in [redacted]

Based upon the testimony and the evidence presented today, I find that Appellant failed to preponderate his burden of proof. The Department properly denied the request for enrollee initiated disenrollment for cause.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for disenrollment.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/23/2009

***** 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.