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. 2010-14364 DISP

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.

After due notice, a hearing was held on [redacted]. [redacted] appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], MDCH Special Disenrollment Program Coordinator, appeared as a witness for the Department.

ISSUE

Did the Department properly disenroll the Appellant from [redacted] on request of the MHP?

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 an adult female Medicaid Beneficiary, age [redacted], who was enrolled in [redacted], a Medicaid Health Plan (MHP). (Exhibit A, page 14)

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 of Medical Services Administration (MSA) received a request for Special Disenrollment from the MHP regarding the Appellant. (Exhibit A, page 10)

4. The request for disenrollment alleged that the Appellant's proposed discharge was based on actions inconsistent with membership, including noncompliance with appropriate use of Emergency Room services, obtaining narcotic pain medication from multiple physicians, failing to seek attention of her primary care physician prior to seeking treatment in the emergency room, and seeking a medication refill after missing a scheduled appointment. (Exhibit A, pages 12-13)

5. On [redacted] following MSA investigation, the Appellant was sent notice that she would be disenrolled from the MHP effective [redacted] and placed in Fee for Service Medicaid owing to noncompliance and actions inconsistent with plan membership. (Exhibit A, page 8)

6. On [redacted], the Appellant filed a request for hearing contesting the disenrollment determination. (Exhibit A, page 7)

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 (DCH), pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with the Health Plan of Michigan 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

(a) 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 repeated use of non-Contractor providers when in-network providers are available; 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 non-compliance, 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. . . (Emphasis supplied) [Exhibit 1, pages 56-57]

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The Department witness testified that after investigation and review, she approved the MHP's Special Disenrollment request. The Department witness stated that the submitted documentation showed actions inconsistent with plan membership, despite efforts to educate the Appellant regarding appropriate use of services and attempts to refer the Appellant to appropriate specialists. The Department witness noted the documentation of emergency room visits for non-emergent conditions such as tooth pain, chronic back pain and ankle sprain, as well as attempts to obtain prescription pain medications from multiple sources.

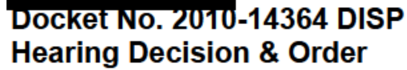
The Appellant testified that after she was complaint after she signed the agreement to stop going to the emergency room for non-emergent conditions. The Appellant explained that she only went to the emergency room for the ankle sprain because this injury occurred at work and her employer told her to go to the emergency room. The Appellant noted that this injury occurred around 2:00 a.m. or 3:00 a.m., when her primary care doctors office was closed. The Appellant testified that other than the work injury, she did stop going to the emergency room for things like dental pain and chronic pain after she signed the agreement to only use the emergency department for life threatening problems. Regarding the referrals to specialists, the Appellant stated that her doctor's office has not followed up with the referrals or calling her back. The Appellant also stated that her doctor is rarely in the office to see her, and she is not willing to see the nurse practitioner instead.

The evidence in this case supports the Department's determination that the Appellant actions were inconsistent with plan membership. The Appellant signed the agreement to only use the emergency department for life threatening problems on [redacted] (Exhibit A, page 22) However, she sought treatment in the emergency room for a rash on [redacted]. The Appellant also went to the emergency room for migraine headache and tooth pain [redacted]. (Exhibit A pages 36-40) The [redacted] emergency department visit was for the work related foot injury in the middle of the night. (Exhibit A, pages 31-35) However, the records document that the Appellant returned to the emergency department on [redacted] seeking additional pain medication for the ankle injury. (Exhibit A pages 28-30)

The Department also established that the MHP made educational and assistive interventions regarding the Appellant's use of emergency room services versus treatment by primary care and specialist physicians. (Exhibit A) Based upon the testimony and the evidence presented, the Department properly granted the MHP's Disenrollment request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly granted the MHP request for Special Disenrollment.



IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 3//19/2009

***** 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.