

**STATE OF MICHIGAN  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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**IN THE MATTER OF:**

██████████,  
Appellant

\_\_\_\_\_ /

**Docket No. 2010-20637 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 ██████████. ██████████ appeared on his own behalf. ██████████, Appeals Review Officer, represented the Department. ██████████, MDCH Special Disenrollment Program Coordinator, appeared as a witness for the Department.

**ISSUE**

Did the Department properly disenroll the Appellant from ██████████  
██████████ on request of the Medicaid Health Plan?

**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 male Medicaid Beneficiary, who was enrolled in ██████████, 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 ██████████, the Department's Medical Services Administration (MSA) received a request for Special Disenrollment from the MHP regarding the Appellant because of verbally abusive behavior. (Exhibit 1, pages 9-33)

4. On ██████████, following MSA investigation, the Appellant was sent notice that he would be disenrolled from the MHP effective ██████████ and placed in Fee for Service Medicaid due to actions inconsistent with plan membership, alleged inappropriate behavior and continued inappropriate use of the transportation benefit for medical care or services. (Exhibit 1, page 7)
5. On ██████████, the Appellant filed a request for hearing contesting the disenrollment determination. (Exhibit 1, page 6)
6. The Appellant filed a timely hearing request; therefore he remains enrolled in the MHP pending the outcome of this hearing. (Testimony)
7. On ██████████, the MSA obtained additional documentation from the MHP. (Exhibit 1, pages 34-37)

### **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 Medicaid Health Plan (MHP) 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

(1) Special Disenrollments

The Contractor may initiate special disenrollment requests to 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 poses a threat to the Contractor or provider. The Contractor is 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 actions inconsistent with plan membership. Examples include, but are not limited to, the repeated use of non-Contractor providers without referral when in-network providers are available; discharge from multiple practices of available Contractor's network providers; inappropriate use of prescription medication or drug seeking behaviors including inappropriate use of emergency room facilities for drug seeking purposes.

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 actions inconsistent with plan membership, the Contractor must document evidence of the Contractor's

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actions to assist the enrollee in correcting the problem, including appropriate physical and mental health referrals. . . (Exhibit 1, page 38)

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The Department witness testified that after investigation and review, she approved the MHP's Special Disenrollment request. The Department witness explained that the documentation from the MHP showed a pattern of verbally abusive behavior as well as inappropriate use of the medical transportation benefit. The Department witness stated that these actions were inconsistent with plan membership, and continued despite the MHP's efforts to work with the Appellant.

The Appellant testified that he never used to have problems with the past transportation person for the MHP. The Appellant stated that the MHP has also been inappropriate with him by treating him like a child as well as getting loud and abusive over the phone. The Appellant noted that he can not always call the MHP five days in advance of an appointment because some are not arranged that far in advance. The Appellant explained that he must make multiple trips to the pharmacy each month to obtain his prescriptions, and that the trip to [REDACTED] was to fill a prescription for a brace. The Appellant did testify that if a doctor changes an appointment he does not call the MHP back regarding the transportation request.

A request for special disenrollment based only on type of verbally abusive behavior documented in this case would not be supported by the contract language. The above cited contract language allows for special disenrollment requests in violent/life threatening situations involving physical acts of violence, physical or verbal threats of violence, or stalking situations. The MHP transcribed the Appellant statements during an [REDACTED] phone conversation and a [REDACTED] voicemail. (Exhibit 1, pages 14 and 17) While the Appellant's language was offensive and contained profanity, there is no documentation that the Appellant made a verbal threat of violence. Therefore, this type of verbally abusive behavior was not sufficient to warrant a special disenrollment request under the violent/life threatening category.

However, the contract language also allows for a special disenrollment for other actions inconsistent with plan membership. The Department witness stated that she considered the Appellant's verbally abusive behavior and inappropriate use of the transportation program to be the other actions inconsistent with plan membership. The Department witness explained that this was not due to one specific incident, but the pattern of how the Appellant communicated with the MHP and utilized the medical transportation benefit. The Department submitted member management logs and a printed history of the Appellant's requests for medical transportation tokens and medical services obtained through the MHP. (Exhibit 1, pages 14-37) In reviewing these records, it is clear that there was poor communication from the Appellant regarding his requests for transportation tokens and how he utilized the tokens.

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The documentation submitted by the Department shows that the Appellant failed to consistently comply with the medical transportation program rules, such as calling at least 5 days in advance of need for transportation or when appointments for which transportation tokens were issued are later cancelled or rescheduled. It is understandable that some appointments are scheduled last minute and the Appellant could not always give 5 days notice. However, 5 days advanced notice should be possible for most doctor's appointments and trips to the pharmacy. Further, the Appellant testified that he does not call the MHP back when an appointment is re-scheduled.

For example, tokens were requested for the ██████████ ██████████ ██████████ physical therapy appointments that were cancelled. (Exhibit 1, pages 30-31) The MHP did not receive a call from the Appellant regarding the missed appointments. (Exhibit 1, page 12) The Appellant did call the MHP on ██████████ requesting transportation for ██████████. The MHP denied this request because the Appellant should have had 2 spare tokens from the cancelled physical therapy appointments. The MHP also noted that a token issued for transportation to the pharmacy was utilized at ██████████ (Exhibit 1, page 12) The Appellant testified that the trip to the medical supply store was to fill a prescription for a brace. However, the Appellant did not clearly explain this to the MHP when he made the transportation request to fill the prescription for the brace. Further, if the Appellant used the tokens from the canceled physical therapy appointments for other pharmacy trips or doctor appointments, he also failed to communicate this to the MHP.

The Appellant testified he feels like the MHP was treating him like a child and picking on him. However, clear communication with the MHP is necessary to administer the transportation benefit. The MHP properly compared the token requests and usage to the Appellant's medical service claims to ensure that the tokens are being appropriately issued and used for medical transportation. The MHP attempted to work with the Appellant regarding his medical transportation requests; though on several occasions they had to disconnect the call due to the Appellant's offensive language. (Exhibit 1, pages 14-17)

Based upon the testimony and the evidence presented, the Department properly granted the MHP's special disenrollment request due to other actions inconsistent with plan membership.

**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: 5/14/2010

**\*\*\* 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.