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. 2010-52489 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 appealing the Department's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held on , and continued to The Appellant appeared without representation. She had no witnesses. , appeals review officer, represented the Department. His witness was , MSA Disenrollment Specialist/MDCH.

ISSUE

Did the Department properly disenroll the Appellant from the ?

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 formerly enrolled in the – she is now a fee for service FFS participant who is "very happy" with her medical care. (*See* Testimony of Appellant)

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

3. On , the Department received a request for Special Disenrollment from the MHP regarding the Appellant. (Department's Exhibit A, p. 14)

4. The request for disenrollment alleged that the Appellant's proposed discharge was based on plan non-compliance; abusive behaviors, failure to follow medical treatment plans, dismissals from or refusals to work with primary care providers. (Department's Exhibit A, p. 12)

5. The MHP further advised the Department that the Appellant had ignored treatment instructions, directed providers in her own version of treatment methods and exited hospitals AMA, misused medications and generally failed to participate in the practice of evidence based medicine. (See Department's Exhibit A, pp. 14-101)

6. On , the Appellant was notified that the MHP request for Special Disenrollment was reviewed and approved by Disenrollment specialist . (Department's Exhibit A, p. 29)

7. On the MHP was notified by the Department that its request for special disenrollment was approved effective . (Department Exhibit A, p. 13)

8. The Appellant was informed of her right to appeal. (Department Exhibit A, p. 12)

9. The instant request for hearing was received by SOAHR on r (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 <u>seriously impairs</u> 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 healthcare 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]

* * *

The Michigan Department of Community Health (MDCH), pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with <u>Health Plus</u> 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

(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 poses 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 actions inconsistent with plan membership. Examples include, but are not limited to, the repeated use of non-Contractor providers without referral or 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. (Emphasis supplied)

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 actions to assist the enrollee in correcting the problem, including appropriate physical and

> mental health referrals. The Contractor must also document that the continued enrollment seriously impairs the Contractor or providers' ability to furnish services to this enrollee or other enrollees. The DCH reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment. The effective disenrollment date shall be 60 days from the date DCH received the complete request from the Contractor that contains all the information necessary for DCH to render a decision. If the beneficiary exercises their right of appeal, the effective disenrollment date shall be no later than 30 days following resolution of the appeal. [2010 Contract at §1-B, page 21 and *See* Department's Exhibit A, p. 101]

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The Department witness, [redacted] testified that the Appellant was disenrolled after MSA investigation and review. She said this action followed extensive attempts to counsel and educate the Appellant on utilization of the managed care services.

[redacted] stated that in this instance the MHP brought ample documentation of PCP office outbursts, failure to follow doctor orders, medical self-management leading to crisis, medical institutional bias and medically contra indicated behaviors also leading to crisis. *See* Department's Exhibit A, pp. 15, 21, 22, and 23.

The Appellant said that she had to search for a long time to find the "wonderful team" who would provide the out-of-the-ordinary treatment she required – while at the MHP. However, at hearing she testified that she is "very happy" with the care she receives now as a FFS recipient.

On review, it is apparent that the Appellant has a belief system[1] that takes her away from traditional medicine and [unfortunately] to the emergency room when her self-directed care fails.

It was this action or inaction by the Appellant which caused the health plan to correctly seek disenrollment because now it was clear that its ability to serve was seriously impaired as evidenced by her own testimony and the record.[2]

The Appellant had no credible testimony to refute the extensive evidence gathered by the MHP as reviewed by the Department. She said she brought the appeal on the chance that she might need a health plan specialist in the future.

1 There was no evidence that the Appellant set forth a religious or moral objection to treatment.
2 The ALJ found the medical records at Department's Exhibit A pages 27, 44, and 62 to be compelling evidence in support of the Department's decision to approve special disenrollment.

The health plans are not allowed to disenroll members owing to adverse changes in health status or because the member manifests uncooperative or disruptive behavior resulting from his or her special needs. [*See generally*, 42 CFR 438.56(b) (2)] As such they take their member where they found her.

The Appellant's long standing, well documented conduct, however, seriously impairs the MHP's ability to furnish needed medical services owing to her conduct alone. While it is true that some MHP members simply require greater effort, the MHP demonstrated significant effort toward servicing an unreceptive member.

Based upon the testimony and the evidence presented today, I find that the Department properly granted [redacted] request for Disenrollment.

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

cc: [redacted]

Date Mailed: 12/1/2010

*** 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.