STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-004068 DIS

[redacted] [redacted] [redacted]

Appellant

_____/

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 telephone hearing was held on [redacted]. The Appellant appeared without representation. She had no witnesses. The Michigan Department of Health and Human Services, formerly Michigan Department of Community Health (MDHHS or Respondent) was represented by [redacted] [redacted], Disenrollment Specialist/MDCH.

State's Exhibit A pages 1-16 were admitted as evidence.

ISSUE

Did the Department properly deny the Appellant/enrollee's request for special dis-enrollment for cause?

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 has been a Medicaid eligible beneficiary since [redacted], resides in [redacted] County, and is in the mandatory population for Medicaid Health Plan enrollment.

2. Appellant has been enrolled in [redacted], one of the contracted Medicaid Health Plans, since [redacted]

3. On [redacted], Respondent Enrollment Services Section (ESS) received a Special Disenrollment – For Cause Request form date stamped as received by Michigan Enrolls on [redacted] for Appellant.

4. On [redacted], the Special Disenrollment request was reviewed by [redacted], who forwarded a response to the Department.

5. On [redacted], the Special Disenrollment – For cause request was denied because: There was no medical information provided from a physician that described active treatment of a serious medical condition or an access to care or services issue that would allow for a change in Medicaid Health Plans outside of the open enrollment period. All of the health plans have prior authorization (PA) processes for some medications. If the PA is denied, the beneficiary and/or the provider can appeal that decision against the health plan on that issue.

6. On [redacted], a denial notification letter regarding the For Cause Special disenrollment action was sent to Respondent with the above referenced information as well as her appeal rights with a Request for Hearing form and postage paid return envelope to Michigan Administrative Hearing System.

7. On [redacted], the Michigan Administrative Hearings System received a hearing request from Appellant.

8. On [redacted] the request for hearing was forwarded to the Enrollment Services Section.

9. On [redacted], the Special disenrollment – For Cause request case file with the Request for Hearing was reviewed by the Michigan Department of Community Health Chief Medical Director, who agreed with the denial of the Special disenrollment request as it was outlined in the [redacted] denial notice.

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….

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 Respondent (MDHHS) pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with [redacted] to provide State Medicaid Plan services to enrolled beneficiaries.

The Department's contract provides, as follows:

<u>Disenrollment Requests Initiated by the Contractor</u>

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:

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

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

c. 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.

A Contractor may not request special disenrollment based on the 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 continued enrollment seriously impairs the Contractor or providers' ability to furnish services to this enrollee or other enrollees. DCH reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment. The effective disenrollment date shall be within 60 days from the date DCH received the complete request from the Contractor that contains all 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.

[Contract at §1-B page 21]

Disenrollment Requests Initiated by the Enrollee

(1) **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.

(2) **Disenrollment for Cause**: The enrollee may request that DCH 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.

[Contract at §1-C, page 22]

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The Department witness testified that the Appellant's request for disenrollment was denied as there was no proof of a lack of access to care, or inability to arrange medical services or active treatment issue that would justify disenrollment outside of the normal open enrollment period.

According to the Department witness, open enrollment is provided to the Appellant in [redacted]

On review, the evidence shows that there was no medical information provided from a physician that would support an access to care or services issue that would allow for a change in Medicaid Health Plans outside of the open enrollment period.

The Appellant failed to meet the burden of proof that the request for disenrollment was justified owing to an active serious medical condition, an access to care issue, lack of specialty care or a quality of care issue.

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 for cause.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

LYL/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.