RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 6, 2016
MAHS Docket No.: 16-005013
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. Petitioner [redacted] and Witness [redacted] appeared on behalf of the Petitioner. [redacted], Special Disenrollment Program Specialist appeared to testify and represent the Department of Health and Human Services (Department or State).

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

ISSUE

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner has been a Medicaid eligible beneficiary since [redacted].

2. Petitioner resides in [redacted] County and is the Mandatory population for Medicaid Health Plan enrollment.

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

4. 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 Petitioner.

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. The health plan has several primary care providers and specialists available to treat within their network of providers.

6. On [redacted], a denial notification letter regarding For Cause Special Disenrollment action was sent to Petitioner.

7. On [redacted], the Michigan Administrative Hearing system received a request for Hearing from Petitioner. The request was forwarded to enrollment Services Section (ESS).

8. On [redacted], the Special disenrollment – for Cause Request case file with request for Hearing was reviewed by the Department Chief Medical Director, who agreed with the denial of the special disenrollment request as it is outlined in the [redacted] denial notification.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be

> administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

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

The Department's contract provides, as follows:

Disenrollment Requests Initiated by the Contractor

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 Petitioner'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 Petitioner 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. [redacted] Healthcare of Michigan has provided the care and services they are responsible to provide to Petitioner. It does not appear that the Petitioner has contacted or worked with the current health plan on a medical issue as described in the disenrollment request. [redacted] Healthcare has not denied a request for Petitioner. [redacted] does have a list of participating providers.

The Petitioner 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.

The Department will consider a change in Medicaid Health Plans outside of the yearly open enrollment period when there is a documented access to care or specialty care provider(s) issue, quality of care issue, if the beneficiary has been enrolled over 90 days and is in the midst of active treatment for a serious medical condition with a provider that has terminated their contract with the current health plan or if the health plan is unable to provide a primary care provider within the contracted 30 mile/30 minute radius/time frame of the beneficiary's residence.

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 Petitioner's request for disenrollment for cause.

IT IS THEREFORE ORDERED that:

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

LL/[redacted]

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Petitioner [redacted]

DHHS Department Rep. [redacted]