[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: March 17, 2021
MOAHR Docket No.: 20-000324
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

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 via video conferencing was held on March 2, 2021. For purposes of hearing, the matter was consolidated with another matter involving Petitioner and a related issue: 20-002175 HHS.

Attorney Elisa Gomez represented Petitioner during the hearing. Petitioner and Kate Beveridge, MI Health Link Ombudsman, testified as witnesses for Petitioner. [redacted], Petitioner's home care provider, was also present for Petitioner, but did not testify as a witness.

Attorney Erin Roumayah represented HAP Empowered, the Respondent Integrated Care Organization (ICO) in this matter. Rhoda Mullins, Manager of Government Membership and Billing Team, and TreKinya Matthews, Manager of Government Programs, testified as witnesses for the ICO. Taysha Morales, Project Coordinator, was also present for the ICO, but did not testify as a witness.

Appeals Review Officer (ARO) Allison Pool represented the Michigan Department of Health and Human Services (MDHHS or Department) in Docket 20-002175 HHS. Brigeda Nelson, Adult Services Worker (ASW), and Allison Repp, Section Manager for the MI Health Link Program, testified as witnesses for the Department. Margo Peterson, Adult Services Supervisor, and Mark Cooley, Contract Manager, were also present for the Department, but did not testify as witnesses.

During the consolidated hearing, the following exhibits were entered into the record:

Petitioner's Exhibits:

1. July 3, 2019 Email from [redacted] to [redacted]
2. July 10, 2019 Email from [redacted] to [redacted]
3. October 8, 2019 Email from [redacted] to MDHHS MHL SR ASSISTANCE
4. October 8-9, 2019 Emails between Dan Wojciak and Mark Cooley
5. October 28-30, 2019 Emails between [redacted] and [redacted]
6. November 18, 2019 Services Approval Notice
7. December 3, 2019 Email from [redacted]
8. December 4, 2019 Email from MI Health Link Enrollment Team to Kate Beson
9. December 5, 2019 Letter from Ms. [redacted] to Ms. [redacted] with Attached Care Logs

ICO's Exhibits:

A. Screenshot of HAP Enrollment System with 02/26/2019 State 834 Data File transaction log

B. Screenshot of HAP Enrollment System with 02/26/2019 State 834 Data File details

C. Screenshot of HAP Enrollment System CMS DTRR transaction log with 04/02/2019 Transaction Reason Code 013

D. Screenshot of HAP Enrollment System CMS DTRR 04/02/2019 Transaction Reason Code 13 details

E. Screenshot of HAP IT CMS DTRR Subreason Code details

F. CMS MAPD Plan Communications User Guide Appendixes Excerpt, Version 12.0, dated February 28, 2018, disenrollment reason codes

G. April 3, 2019 HAP Empowered Letter to Petitioner

H. MDHHS Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status - Notification of Involuntary Disenrollment ("Exhibit 21")

I. MDHHS Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR) ("Exhibit 16")

J. CHAMPS Member Enrollment Data – Screenshot March 1, 2019 – May 31, 2019

K. CHAMPS Member Enrollment Data – Screenshot June 1, 2019 – August 31, 2019

L. CHAMPS Member Enrollment Data – Screenshot September 1, 2019 – November 30, 2019

M. Screenshot of HAP Pega System with July 2, 2019 Customer Service call log details

Department's Exhibits:

1. Hearing Packet dated February 27, 2020

4. Program Enrollment in State & CMS Systems, eligibility information in CHAMPS and service requests received by MI Health Link team.

5. Service requests received by MI Enrolls and the Enrollment Services Section[1]

ISSUE

Did Respondent properly terminate Petitioner's State Plan personal care services?

FINDINGS OF FACT

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

1. HAP Empowered is an Integrated Care Organization (ICO) contracted by the Michigan Department of Health and Human Services (Department or MDHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the MI Health Link managed care program.

[1] The Department's proposed exhibits #2 and #3 were not admitted.

2. As of February 1, 2019, Petitioner was enrolled in the MI Health Link Program and authorized for services through the ICO. (ICO's Exhibit J; Department's Exhibit #1, page 21; Testimony of Manager of Government Membership and Billing Team).

3. On or about February 25, 2019, the Department sent Petitioner written notice regarding her Medicaid eligibility. (Petitioner's Exhibit #2, page 9; Testimony of Petitioner).

4. In that notice, the Department provided that, as of April 1, 2019, Petitioner was not eligible for full Medicaid, but was eligible for the Medicare Savings Program. (Petitioner's Exhibit #2, pages 9-10).

5. Petitioner did not file a request for hearing or take any other action with respect to that notice. (Testimony of Petitioner).

6. On February 26, 2019, the ICO received notice from the State of Michigan that Petitioner's Medicaid eligibility would end on March 31, 2019 and Petitioner would be disenrolled from the MI Health Link Program. (ICO's Exhibit B; Testimony of Manager of Government Membership and Billing Team).

7. The ICO took no action in response to that notice. (Testimony of Manager of Government Membership and Billing Team).

8. On April 1, 2019, Petitioner's Medicaid scope of coverage changed and, as of that date, she no longer had full Medicaid coverage. (Department's Exhibit #1, pages 19-20; Testimony of Section Manager for the MI Health Link Program).

9. On April 2, 2019, the ICO received notice that CMS had confirmed Petitioner's disenrollment. (ICO's Exhibits C and D; Testimony of Manager of Government Membership and Billing Team).

10. On April 3, 2021, the ICO mailed a letter to Petitioner. (ICO's Exhibit J; Testimony of Manager of Government Membership and Billing Team).

11. In part, that letter stated:

> **Your HAP Empowered MI Health Link coverage is ending.**
> You asked us to disenroll you from HAP Empowered MI Health Link. You will no longer be in HAP Empowered MI Health Link as of **March 31, 2019.** You may want to tell your doctors and other providers that there may be a delay in updating your records.

What if I think there was a mistake?
If you did not ask to leave HAP Empowered MI Health Link and want to stay in HAP Empowered MI Health Link, call Michigan ENROLLS toll-free at 1-800-975-7630. Call 1-888-263-5897 if you use TTY. Office hours are Monday through Friday, 8 AM to 7 PM.

* * *

If you are receiving personal care services in your home, authorization for these services will end on **March 31, 2019.**

- If you are still eligible for Medicaid and would like to receive personal care services through the Michigan Medicaid Home Help Program, contact your local Michigan Department of Health and Human Services Office to apply for Home Help. **You must do this as soon as possible.**
- If you do not apply, your personal caregiver will not be paid for services delivered after **March 31, 2019.**
- If you need your local office's contact information, please call Michigan ENROLLS toll-free at 1-800-975-7630. Call 1-888-263-5897 if you use TTY. Office hours are Monday through Friday, 8 AM to 7 PM.
- You can also find your **local Department of Health and Human Services office address and phone number at:** https://www.mdhs.michigan.gov/CompositeDirPub/CountyCompositeDirectory.aspx.

ICO's Exhibit G, pages 1-2

12. Petitioner never received the letter from the ICO. (Testimony of Petitioner).

13. Beginning in April of 2019, Petitioner's Medicaid card stopped working. (Testimony of Petitioner).

14. She also started receiving new medical bills over the next month.

(Testimony of Petitioner).

15. She further discovered that her care provider through the MI Health Link Program had not received payment for April of 2019. (Testimony of Petitioner).

16. On May 28, 2019, Petitioner contacted the MI Health Link Ombudsman for assistance. (Petitioner's Exhibit #1, pages 2-3; Testimony of MI Health Link Ombudsman).

17. That same day, the MI Health Link Ombudsman began communicating with MI Enrolls, which indicated initially that Petitioner did not have full Medicaid coverage, but that it would submit a complaint to the Department. (Petitioner's Exhibit #1, pages 2-3).

18. In subsequent conversations or communications, MI Enrolls further indicated that Petitioner did not have full Medicaid coverage; and, instead, only had Qualified Medicare Beneficiaries (QMB) coverage that only covers Medicare premiums. (Petitioner's Exhibit #1, pages 3-4; Petitioner's Exhibit #2, pages 8-11).

19. MI Enrolls further advised Petitioner to contact her local case worker if there was an issue with Medicaid eligibility. (Petitioner's Exhibit #2, pages 8-11).

20. On July 2, 2019, the MI Health Link Ombudsman also spoke with the ICO, who confirmed that its records provided that Petitioner did not have full Medicaid eligibility. (ICO's Exhibit M; Petitioner's Exhibit #1, page 3; Testimony of MI Health Link Ombudsman).

21. During that same period Petitioner and the MI Health Link Ombudsman were in communication with Petitioner's local case worker for the Department regarding Petitioner's eligibility for Medicaid and the MI Health Link Program. (Petitioner's Exhibit #1, page 3; Petitioner's Exhibit #5, pages 21-22; Testimony of Petitioner; Testimony of MI Health Link Ombudsman).

22. Effective August 1, 2019, Petitioner was approved for Medicaid through the Healthy Michigan Plan. (Department's Exhibit #1, page 19).

23. On October 8, 2019, Petitioner was referred for Home Help Services (HHS) through the Department. (Department's Exhibit #1, page 13).

24. On November 5, 2019, the ASW completed an assessment with Petitioner. (Department's Exhibit #1, page 12).

25. On November 18, 2019, the ASW met with Petitioner's care provider. (Department's Exhibit #1, page 13).

26. That same day, the Department sent Petitioner a Services Approval Notice stating that, effective November 18, 2019, Petitioner was approved for $[redacted] per month of HHS. (Petitioner's Exhibit #6, page 24; Department's Exhibit #1, page 13).

27. On January 27, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter.

28. While originally identified as a case involving Petitioner's HHS through the Department, the matter was subsequently recoded as an ICDE case, with the ICO as the Respondent, following a prehearing conference.

29. The hearing was also put on hold because Petitioner had requested an in-person hearing while MOAHR had suspended all in-person administrative hearings due to the COVID-19 pandemic.

30. Following a prehearing conference on December 2, 2020 and a status conference on January 7, 2021, it was determined that the hearing would be held via video conferencing.

31. On March 2, 2021, the hearing in this matter was held and completed as scheduled via conferencing.

CONCLUSIONS OF LAW

As discussed above, Petitioner was previously authorized for services through the Respondent ICO pursuant to the MI Health Link Program. With respect to that program, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 1 – GENERAL INFORMATION**
>
> Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.
>
> *MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and*

primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

SECTION 2 – ELIGIBILITY AND SERVICE AREAS

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

* * *

Excluded populations:

- Individuals under age 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56
- Individuals not living in one of the four demonstration regions
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
- *Individuals without full Medicaid coverage* (they have spenddowns or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital

- Individuals with commercial Health Maintenance Organization (HMO) coverage

- Individuals with elected hospice services prior to MI Health Link program enrollment

- Individuals with Medicaid who reside in a State Veterans' Home

* * *

SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy

- Medicaid State Plan services, including personal care services and hearing aid coverage . . .

* * *

5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently

> receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.
>
> *MPM, April 1, 2019 version*
> *MI Health Link Chapter, pages 1-2, 5*
> *(Italics added for emphasis by ALJ)*

Here, pursuant to the above polices, the ICO terminated Petitioner's personal care services. Specifically, as testified to by its Manager of Government Membership and Billing Team, the ICO terminated Petitioner's services at the direction of the State of Michigan after the State of Michigan, not the ICO, determined that Petitioner did not have full Medicaid coverage and was therefore ineligible for the MI Health Link Program.

The ICO's Manager of Government Membership and Billing Team also described the timeline of events, with State of Michigan informing the ICO on February 26, 2019 that Petitioner's eligibility would end on March 31, 2019 and it would be disenrolling Petitioner; the ICO taking no action at that time because the file from the State is just a "heads up"; the ICO receiving a daily transaction report on April 2, 2019 indicating that CMS had confirmed the disenrollment; and the ICO's system automatically processing the disenrollment and sending out a letter the next day.

The ICO's Manager of Government Membership and Billing Team further testified that, due to an error in the system, the reason for disenrollment identified in the letter, *i.e.,* that Petitioner asked to be disenrolled, was incorrect. However, she also testified that the other information in the letter, including what Petitioner was to do if she disagreed with the action was correct. She also noted that the form and content of the disenrollment letters, both the incorrect one sent in this case and the one that should have been sent, are provided by the State of Michigan and that the ICO is just directed to send them.

The ICO's Manager of Government Membership and Billing Team also testified that its records only reflect one call from Petitioner after the disenrollment and that during the call, on July 2, 2019, Petitioner was advised that she did not have full Medicaid coverage.

The Department's Section Manager for the MI Health Link Program similarly testified that its records provide that Petitioner lost full Medicaid coverage as of April 1, 2019, and that Petitioner needed to have full Medicaid coverage to be eligible for the MI Health Link Program. She also testified that, when the program was contacted by

Petitioner or the MI Health Link Ombudsman on Petitioner's behalf, they were advised to work with the Department's local office to resolve any Medicaid eligibility issues.

The MI Health Link Ombudsman testified that she was contacted by Petitioner on May 28, 2019 regarding her care provider through the MI Health Program not getting paid, with Petitioner also reporting that she had been told different things as to why, and that they tried numerous ways to resolve the issue, including contacting with the ICO, MI Enrolls, and Petitioner's Medicaid Eligibility Case Worker at her local Department office.

Regarding any contact with the ICO, the MI Health Link Ombudsman testified that she called on July 3, 2019 and that the ICO confirmed that Petitioner did not have active Medicaid.

She also testified that, during her contacts with MI Enrolls or the Department's local office, over the course of several months and both before-and-after she called the ICO, she was informed that Petitioner did not have full Medicaid as of April 1, 2019, but that there appeared to be confusion over the issue and an error made regarding Petitioner's Medicaid eligibility. She further testified that she spoke with Petitioner's Case Worker in October of 2019, and that Petitioner's Medicaid was reinstated by that time.

Petitioner testified that she first noticed issues with her Medicaid near the end of April of 2019, when her direct card would not work. She also testified that the Social Security Office has her as "deceased" and that, once she got that corrected, she was advised to speak with her Case Worker at her local Department office. She further testified that she then spoke with the Case Worker, who advised her that she only had QMB coverage, but that it should not be an issue for the MI Health Link Program.

Petitioner also testified that she never received any written notice from the ICO, but that she did receive an eligibility notice from the Department in February of 2019 stating that she was both ineligible and eligible. Petitioner did not file an appeal or take any other action in response to that notice because it said that she was eligible. Petitioner also confirmed that the address on the letter the ICO purportedly sent was accurate.

Petitioner further testified that she then began receiving bills in about a month and noticed that her care provider was not getting paid, so contacted the MI Health Link Ombudsman in May of 2019.

Petitioner also testified that she applied for HHS through the Department on a few occasions, with at least one application not accepted because she did not have active Medicaid.

In appealing the ICO's action, Petitioner bears the burden of proving by a preponderance of the evidence that the ICO erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the ICO's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has met her burden of proof and that the Respondent ICO's decision must therefore be reversed.

Based on the information it had at the time, the ICO's decision to terminate Petitioner's services through the MI Health Link Program was correct. An individual must have full Medicaid coverage to be eligible for the program and it is undisputed that Petitioner did not have full Medicaid coverage as of the effective date of the termination, *i.e.,* April 1, 2019. Moreover, it is also clear that the ICO does not make Medicaid eligibility determinations and that it must therefore rely on what the State of Michigan and the Department of Health and Human Services have decided regarding eligibility.

To the extent Petitioner disputes the eligibility determination, her dispute is not with the ICO and the time to raise it with the Department was when she received her eligibility notice in February of 2019. While the undersigned Administrative Law Judge appreciates that the notice may have been confusing, with the notice stating that Petitioner was not eligible as of April 1, 2019 and that she was eligible and had full coverage for the Medicare Savings Program, the crux of that notice was that Petitioner would be receiving assistance with payments for her Medicare coverage, but was not receiving any other form of Medicaid.[2] Moreover, while Petitioner subsequently regained some sort of Medicaid coverage, for reasons the record is silent on, that approval was not retroactive and, regardless, Petitioner never reapplied for services through the ICO and the issue of Petitioner's Medicaid eligibility is not before the undersigned Administrative Law Judge.

Nevertheless, while the termination of services itself was proper, the ICO erred in this case by failing to send Petitioner proper notice.

Regarding notice and appeals through the MI Health Link Program, the MPM only states:

> **SECTION 15 – APPEALS**
>
> The three-way contract establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the ICO or contracted entities that would fall under the grievance or appeals processes available to individuals through Medicare and Medicaid guidelines.
>
> *MPM, April 1, 2019 version*
> *MI Health Link Chapter, page 63*

[2] *See, e.g.,* Bridges Eligibility Manual (BEM) 165 on the Medicare Savings Program.

None of the parties provided a copy of the three-way contract referenced in the MPM, but Section 2.11.2.1 of the Michigan Demonstration Three-Way Contract provides:

> Notice of Adverse Action, or Adverse Benefit Determination– *In accordance with 42 C.F.R. §§ 438.404, 422.568 and 422.570, the entity must give the Enrollee written notice of any Adverse Action, or Adverse Benefit Determination. Such notice shall be provided at least ten (10) calendar days in advance of the date of its action, in accordance with 42 C.F.R. § 438.404.* An Enrollee, a provider or authorized representative acting on behalf of an Enrollee and with the Enrollee's written consent may Appeal the entity's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee, provider or authorized representative acting on behalf of an Enrollee and with the Enrollee's consent may also Appeal the entity's delay in providing or arranging for a Covered Service.
>
> *Michigan Demonstration Three-Way Contract*
> *Effective January 1, 2018*
> *Page 143*
> *(Italics added for emphasis by ALJ)*

Moreover, regarding disenrollments, the Michigan Demonstration Three-Way Contract further provides:

> 2.3.7 Disenrollment
>
> 2.3.7.1.
>
> *The ICO shall have a mechanism for receiving timely information about all disenrollments, including the effective date of disenrollment, from CMS and MDHHS or its authorized agent.* All disenrollment-related transactions will be performed by CMS, MDHHS or its authorized agent. Enrollees can elect to disenroll from the ICO or the Demonstration at any time and enroll in another ICO, a MA-PD plan, PACE (if eligible and the program has capacity); or may elect to receive services through Medicare FFS and a prescription drug plan and to receive Medicaid FFS and any waiver programs (if eligible). A disenrollment received by CMS, MDHHS or its authorized agent, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.7.2

The ICO shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

* * *

2.3.7.3.3.

The ICO will notify the Enrollee in writing when the Enrollee no longer meets eligibility requirements for Enrollment in the ICO.

2.3.7.4. Required Involuntary Disenrollments.

2.3.7.4.1.

MDHHS and CMS shall terminate an Enrollee's coverage upon the occurrence of any of the conditions enumerated in Section 40.2 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance or upon the occurrence of any of the conditions described in this section. Except for the CMT's[3] role in reviewing documentation related to an Enrollee's alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering disenrollment transactions described elsewhere in this Contract.

Michigan Demonstration Three-Way Contract
Effective January 1, 2018
Pages 44-46
(Italics added for emphasis by ALJ)

[3] **Contract Management Team (CMT)** — A group of CMS and MDHHS representatives responsible for overseeing the contract management functions outlined in Section 2.2 of the Contract.

Section 40 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, referenced in both the above contract and in sample notice used by the ICO[4], provides in part:

> **40 - Disenrollment Procedures**
>
> Disenrollments are elections made after the effective date of enrollment into an MMP.[5] (Note – disenrollments are different than cancellations, which occur before the effective date of enrollment.) A disenrollment may be accompanied by a request to opt out of future passive enrollments into an MMP, and potentially a request to opt out of future auto-enrollments into a Medicare Prescription Drug Plan (also known as Part D) (see §30.2.5.G and §40.1).
>
> Except as provided for in this section, a state or MMP may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While a state or MMP may contact members to determine the reason for disenrollment or to explain how Medicaid and Medicare coverage will be provided moving forward, the state or MMP must not discourage members from disenrolling after they indicate their desire to do so. The state must apply disenrollment policies in a consistent manner for similar members in similar circumstances.
>
> An MMP must accept disenrollment requests it receives through the state. MMPs may not accept disenrollment requests directly from individuals and process such requests themselves, but instead, must forward the request to the state within two business days, unless the state has delegated enrollment activities to the MMP. Disenrollments from an MMP without an accompanying request to enroll in a Medicare health or drug plan will return the individual to Original Medicare; the individual will be auto-enrolled by CMS into a Medicare Prescription Drug Plan, and can access the LI NET transitional PDP during any coverage gap.
>
> * * *

[4] *See* Model Notices of Disenrollment in ICO's Exhibits H and I.

[5] Integrated Medicare-Medicaid Plans (MMPs)

40.2 - Required Involuntary Disenrollment

*The state **must** disenroll a member in the following cases.*

1. A change in residence (includes incarceration (§40.2.7) – see below) makes the individual ineligible to remain enrolled in the MMP (§40.2.1);

2. *The member loses Medicaid eligibility or additional state-specific eligibility requirements (§40.2.3);*

3. After period of deemed continued eligibility ends without the individual regaining Medicaid eligibility (§40.2.3.2);

4. The member dies (§40.2.4);

5. The MMP's contract with CMS is terminated, or the MMP reduces its service area to exclude the member (§40.2.5);

6. The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage (§40.2.6); or

7. The member is not lawfully present or loses lawful presence status (§40.2.8).

Incarceration - A member who is incarcerated (exception outlined in §10.2) is considered to be residing outside the MMP's service area, even if the correctional facility is located within the MMP's service area. However, states must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by the state or by CMS. Individuals who are ineligible due to confirmed incarceration may not remain enrolled in a MMP. See §40.2.7 for more information.

Unlawful Presence - A member is considered unlawfully present if they lose lawful presence status in the United States (8 CFR §245.1). Individuals who are ineligible due to unlawful presence may not enroll in an MMP or remain enrolled in a MMP. See §40.2.8 for more information.

Notice Requirements *- In situations where the state disenrolls the member involuntarily on any basis except*

death, loss of Medicare entitlement, incarceration, or unlawful presence, notices of the upcoming disenrollment must be sent and must meet the following requirements. All disenrollment notices must:

1. *Advise the member that the state is planning to disenroll the member and explain why such action is occurring;*

2. *Be mailed to the member before submission of the disenrollment transaction to CMS;*

3. *Include an explanation of the member's right to a hearing under the state's grievance procedures, if applicable. This explanation is not required if the disenrollment is a result of contract or plan termination or service area reduction, since a hearing would not be appropriate for that type of* disenrollment; and

4. Notice should be sent to the member within 10 calendar days of receipt of the CMS DTRR. For more information please also see the Summary of Notice Requirements.

* * *

40.2.3 - Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An individual cannot remain a member in an MMP if he or she is no longer eligible for Medicaid benefits or no longer meets other criteria outlined in the Memorandum of Understanding, the three-way contract, or Appendix 5. Generally, an individual who loses Medicaid eligibility or loses eligibility based on state-specific requirements is disenrolled from the MMP on the first of the month following the state's notification to the MMP of the individual's loss of eligibility. This applies even in cases of retroactive Medicaid termination. However, for the loss of Medicaid eligibility only, MMPs may voluntarily elect to offer a period of deemed continued eligibility to their members, as outlined in §40.2.3.2.

Individuals who experienced a short-term loss of Medicaid retain the option to enroll in an MMP at any time during that

benefit year once Medicaid has been regained. The state may passively enroll the individuals the following year as outlined in §30.2.5 or rapidly re-enroll the individual as outlined in §40.2.3.3. Please note that all rapid re-enrollment transactions submitted by the state (§40.2.3.3) to the MMP must be accepted.

If an individual experiences a loss of Medicaid and is disenrolled, but regains eligibility before the disenrollment takes effect (e.g., before the first of the upcoming month), the individual should remain in coverage as though the individual was never disenrolled. The state should restore the enrollment in its records and cancel the disenrollment action from CMS's records as outlined in §50.3.3. The individual does not qualify for rapid-reenrollment in this instance as he or she has regained eligibility prior to the disenrollment taking effect (§40.2.3.3).

40.2.3.1 - General Disenrollment Procedures due to Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An MMP must continue to offer the full continuum of MMP benefits through the end of the calendar month in which the state notifies the MMP of the loss of Medicaid eligibility or loss of state-specific requirements. The beneficiary must also be notified of the involuntary disenrollment following the notice requirements below.

States are limited to only one passive enrollment of the individual in a calendar year, following parameters outlined in §30.2.5. However, an individual who was passively enrolled into the MMP and subsequently loses eligibility and is disenrolled may be rapidly re-enrolled within in the same calendar year into a MMP upon regaining Medicaid or state-specific eligibility no more than 2 months from the loss of their Medicaid eligibility (see §40.2.3.3 for more details on rapid re-enrollment).

Notice and Transaction Requirements – *States are to follow normal protocols regarding notifying individuals of the loss of Medicaid eligibility. With regard to involuntary disenrollment from the MMP, the state must provide each member a written notice (see Exhibit 21) regarding the disenrollment due loss of Medicaid or state-specific eligibility at least 10 calendar days prior to the disenrollment effective*

> *date.* The notice must include information regarding the disenrollment effective date and the Medicare SEP for "dual eligible" individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and who recently lost dual eligible status. Please see section §20.1.1 for more information on the SEP for individuals who gain, lose, or have a change in their dual or LIS status.
>
> *If a determination regarding the loss of Medicaid or state-specific eligibility occurs within the last 10 days of the month, the state must provide the affected member a written notice of disenrollment regarding the loss of eligibility within 3 business days of its determination. In this situation, the state is also strongly encouraged to call these affected members as soon as possible (within 1-3 calendar days) to provide the disenrollment effective date, to explain that the MMP will no longer cover services as of that date and to convey that the individual will have Original Medicare.* For individuals who retain LIS status, CMS will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.
>
> States must submit a disenrollment transaction to CMS no later than 3 business days following the date Medicaid or other state-specific eligibility requirement ended. States can attempt to cancel the disenrollment by submitting TC 81-Cancellation Disenrollment transaction if the beneficiary's Medicaid status has been restored before the disenrollment effective date. If unsuccessful in cancelling the disenrollment, the state must submit the case to the CMS Retroactive Processing Contractor (RPC).
>
> *Medicare-Medicaid Plan Enrollment and Disenrollment Guidance*
> *Pages 52, 55-56, 61-62*
> *(Italics added for emphasis by ALJ)*

Accordingly, given the above policy, contract, regulations and guidance, the ICO erred in sending notice in this case.

As an initial matter, it is undisputed that the ICO erred in sending the notice as it identified an incorrect reason for the disenrollment and termination. While the letter references Petitioner asking to be disenrolled, all parties agree that Petitioner never

asked to be disenrolled and both the ICO's representative and witness expressly acknowledged the error during the hearing.

Moreover, while the ICO argues that the error in the notice was harmless because, even if it identified the wrong reason for disenrollment, the other information in the letter, including what Petitioner was to do if she disagreed, was correct and Petitioner was fully apprised of her options, that argument fails to account for the lack of advance notice.

Regarding notice, the MPM references the three-way contract, which in turn references federal regulations requiring advance notice regarding a termination of services, including 42 CFR 438.404, and provides that the ICO both must have a mechanism for both timely receiving information about all disenrollments and notifying an enrollee in writing when the enrollee no longer meets eligibility requirements.

Similarly, the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance referenced in the three-way contract provides that, while a member must be disenrolled when the member loses Medicaid eligibility, a disenrollment notice must be sent and such notice must advise the member that the state is planning to disenroll the member and explain why such action is occurring; be mailed to the member before submission of the disenrollment transaction to CMS; and include an explanation of the member's right to a hearing under the state's grievance procedures, if applicable.

Furthermore, the Guidance provides that, in addition to following normal protocols regarding notifying individuals of the loss of Medicaid eligibility, a written notice regarding a disenrollment from the MI Health Link Program due to a loss of Medicaid or state-specific eligibility must also be provided at least 10 calendar days prior to disenrollment effective date if possible. Moreover, while the Guidance generally refers to "the state" providing the required notice, it also specifically refers to the sample notice that the Respondent ICO sent in this case as part of its arrangement with the State.

Here, the ICO received notification from the State of Michigan on February 26, 2019 that Petitioner's Medicaid coverage was ending on March 31, 2019 and that Petitioner would have to be disenrolled from the MI Health Link Program. However, the ICO took no action in response to that notification as required and provided Petitioner with no advance notice regarding the termination of services and disenrollment in this case. Moreover, while the ICO's witness testified that the ICO did not take any action because the notification from the State was just a heads up, that basis for not sending the required notice appears to be unsupported by any law or policy and the ICO erred by only sending a notice in April of 2019 that identified a retroactive action.

Accordingly, even if the notice was sent as argued by the ICO, it was sent too late and it misidentified the reason for the action; and the ICO's action must therefore be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent ICO improperly terminated Petitioner's personal care services.

IT IS, THEREFORE, ORDERED that:

> Respondent's decision is **REVERSED**, and it must initiate a reassessment of Petitioner's services.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contacts

Allison Repp
Karen Everhart
400 S Pine Street, 5th Floor
CAPITAL COMMONS
LANSING, MI 48909
ReppA@michigan.gov
EverhartK1@michigan.gov

DHHS Department Rep.

M. Carrier
Appeals Section
PO Box 30807
Lansing, MI 48933
MDHHS-Appeals@michigan.gov

Agency Representative

Allison Pool
MDHHS Appeals Section
PO Box P.O. Box 30807
Lansing , MI 48909
MDHHS-Appeals@michigan.gov

Counsel for Petitioner

Elisa M. Gomez
2727 Second Ave, Suite 301
Detroit, MI 48201
egomez@lakeshorelegalaid.org

Counsel for Respondent

Erin Diesel Roumayah
Office of the General Counsel
2850 W. Grand Blvd
Detroit, MI 48202
eroumay1@HAP.ORG

Community Health Rep

HAP Empowered
Attn: Vernal T Tiller, PhD, RN
P O Box 2578
Detroit, MI 48202
vtiller@HAP.ORG

Petitioner

[redacted]
[redacted]
[redacted], MI [redacted]