

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

**IN THE MATTER OF:**

**Docket No. 2013-50500 DISC**

██████████

████████████████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held by telephone on ██████████ Appellant appeared and testified on her own behalf. ██████████ Medical Exception and Special Disenrollment Program Specialist, represented the Department of Community Health.

**ISSUE**

Did the Department properly deny Appellant's request to receive a Special Disenrollment-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. Appellant is a █████ year-old Medicaid beneficiary who has been diagnosed with hypertension, benign; chronic obstructive pulmonary disease; back pain, lumbago; sciatica; degenerative joint disease/osteoarthritis; hypothyroidism; hyperlipidemia; and Raynaud's syndrome. (Respondent's Exhibit A, page 10).
2. Appellant resides in ██████████ and is a member of the population required to enroll in a Medicaid Managed Health Plan (MHP). (Testimony of ██████).
3. Since ██████████ Appellant has been enrolled in ██████████, a MHP. (Testimony of ██████).

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4. On ██████████, the Department received a Request for Special Disenrollment For-Cause from Appellant regarding ██████████
5. That request was denied on ██████████
6. Appellant appealed the denial, but the Department's decision was upheld in a decision and order issued by Administrative Law Judge ██████████ on ██████████
7. Appellant then filed a request for rehearing, but her request for rehearing was denied in an order issued by Administrative Law Manager ██████████ on ██████████
8. Appellant also obtained a prescription from her primary care physician stating that Appellant has multiple medical problems and needs to have "straight Medicaid" due to her need to see multiple physicians. (Respondent's Exhibit A, page 19).
9. Appellant further contacted the office of ██████████ ██████████ ██████████. That office initiated an inquiry regarding how to proceed to have the decision on Appellant's disenrollment reconsidered based on new information. (Respondent's Exhibit A, page 23).
10. The Department's Enrollment Services Section (ESS) received notice of that legislative inquiry on ██████████ and a review of Appellant's request was conducted. (Respondent's Exhibit A, pages 24-25, Testimony of ██████████).
11. On ██████████ the Department sent Appellant a written denial of her Special Disenrollment-For Cause request. (Respondent's Exhibit A, pages 6-7).
12. Specifically, that denial provided:

Your request has been denied for the following reason(s):

The medical information provided was from a doctor that works with your health plan or accepts referrals. The information did not describe an access to care/services issue that would allow for a change to Fee-For-Service (FFS) Medicaid. Our records show that you have been enrolled in ██████████ since ██████████ is your primary care provider through ██████████ Per telephone contact with ██████████ office manager,

the health plan has several specialists available to treat you and that you are currently being referred to specialists that work with [REDACTED] for your multiple medical conditions. They advised that they filled out the information on the prescription form [REDACTED] because you asked the doctor to do so. They did confirm that you have multiple medical problems, need specialty care and are receiving specialty care through your health plan. They do not know of any "FFS only specialists that are treating you or that they have tried to refer you to that would allow for the possible disenrollment into the FFS Medicaid setting. The office manager did state that they have to prior authorize several medications because you are specifically asking to have medications that are not on the preferred drug formulary, such as the medication Zella. The office manager stated that many of the medications would have to be prior authorized in the FFS setting as well. To date, there has been no information from a non-participating doctor actively treating you for a serious medical condition. Your health plan can provide and arrange for any medically necessary Medicaid covered service that you need. You can call [REDACTED] at [REDACTED] if you have any questions, if you want a case manager to work with you and your doctor(s) to help set up your medical care, if you need help finding a doctor, if you want to change your doctor, or if you need help making arrangements for specialty care or services. [REDACTED] works with several primary care and specialty care provider networks available to you. In addition, your doctor can also ask that you be referred out-of-network for specialty care if medically necessary and appropriate to do so.

You will remain with [REDACTED] at this time. You can call [REDACTED] at [REDACTED] to find out when your next open enrollment period is if you want to change to another health plan. Because you are in the mandatory population for enrollment in a Medicaid Health Plan, a change to FFS Medicaid setting will only be considered on a time limited basis for you to complete treatment of a serious medical condition from a physician that has been actively

treating you who does not work with any of the Medicaid Health Plans. No information has been provided to support that charge.

*Respondent's Exhibit A, pages 6-7*

13. On ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Appellant. (Respondent's Exhibit A, pages 8-15).
14. The request for hearing was originally docketed by MAHS as another request for rehearing.
15. However, it was subsequently re-coded as a new DISC case in ██████████.
16. On ██████████ a hearing was held in this matter.

## **CONCLUSIONS OF LAW**

### **Timeliness of Appeal**

At the onset of the hearing, the Department's representative moved for dismissal on the basis that Appellant's request for hearing was untimely.

The Social Security Act and the federal regulations which implement the Social Security Act require an opportunity for fair hearing to any recipient who believes the Department may have taken an action erroneously. See 42 CFR 431.200 *et seq.* However, the opportunity for fair hearing is limited by a requirement that the request be made within 90 days of the Waiver Agency's negative action:

Request for hearing.

\* \* \*

(d) The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

*42 CFR 431.221(d)*

Moreover, the notice of action in this case clearly provided that any request for hearing "must be in writing and received within ninety ████████ days of the date of this letter." (Respondent's Exhibit A, page 7).

Here, the notice of denial was dated and mailed on ██████████ while the request for hearing was received on ██████████. Therefore, the issue of timeliness turns on whether the date the notice of denial was mailed counts as Day █ of the █ day period for filing an appeal. If yes, the appeal was filed on █ day and is untimely. If no, the appeal was filed on the █ day and is timely.

The Department's representative asserted that that the Department deems the date the notice was mailed as Day █. However, she offers no basis or support for that assertion.

Moreover, her statement appears to conflict with the general rule that the day of the denial itself does not count. For example, Michigan Court Rule 1.108 provides:

#### Rule 1.108 Computation of Time

In computing a period of time prescribed or allowed by these rules, by court order, or by statute, the following rules apply:

(1) The day of the act, event, or default after which the designated period of time begins to run is not included. The last day of the period is included, unless it is a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order; in that event the period runs until the end of the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order.

(2) If a period is measured by a number of weeks, the last day of the period is the same day of the week as the day on which the period began.

(3) If a period is measured by months or years, the last day of the period is the same day of the month as the day on which the period began. If what would otherwise be the final month does not include that day, the last day of the period is the last day of that month. For example, "2 months" after January 31 is March 31, and "3 months" after January 31 is April 30.

Given the general rule and the lack of any support for the Department's position, this Administrative Law Judge finds that the date the notice was mailed is not included in the designated █ day period for filing a request for hearing. Accordingly, this Administrative Law Judge also finds that the request for hearing was timely filed and that he has jurisdiction over this matter.

## Denial

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.

On May 30, 1997, the Department was notified of the Health Care Financing Administration's approval of its request for a waiver of certain portions of the Social Security Act to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Qualified Health Plans.

The Department of Community Health, pursuant to the provisions of the Social Security Act Medical Assistance Program, therefore contracts with MHPs to provide State Medicaid Plan services to enrolled beneficiaries.

As discussed above, Appellant is a member of the population required to enroll in a MHP and she has been enrolled in ██████████ since ██████████ ██████████.

Appellant is dissatisfied with the process of accessing health care benefits through the MHP and has requested disenrollment from the Molina Healthcare for cause.

The contract between the MHP and the Department as well as the federal regulations governing Medicaid both provide that a beneficiary can disenroll from a MHP for cause. (Respondent's Exhibit A, pages 31-37).

For example, the Department's contract with the MHP specifies the conditions for enrollment termination, as required under federal law:

### C. Disenrollment Requests Initiated by the Enrollee

\* \* \*

#### (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 plan. Reasons cited in a request for disenrollment for cause may include:

- Enrollee's current health plan does not, because of moral or religious objections, cover the service

the enrollee seeks and the enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

- Lack of access to providers or necessary specialty services covered under the Contract. 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.
- Concerns with quality of care.

*Comprehensive Health Care Program  
Contract No. 071B02000  
FY2013, Print Version January 23, 2013  
(Respondent's Exhibit A, pages 31-32)*

Similarly, the applicable federal regulations provide in part:

(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.

\* \* \*

(c) Disenrollment requested by the enrollee. If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a beneficiary 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 beneficiary's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the beneficiary 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 beneficiary to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in § 438.702(a)(3).

(d) Procedures for disenrollment--

(1) Request for disenrollment. The beneficiary (or his or her representative) must submit an oral or written request--

(i) To the State agency (or its agent); or

(ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHP, PAHPs, and PCCMs to process disenrollment requests.

(2) Cause for disenrollment. The following are cause for disenrollment:

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a caesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access

to providers experienced in dealing with the enrollee's health care needs.

42 CFR 438.56

Here, Appellant is seeking disenrollment on the basis that she has received poor care through the MHP and has been unable to access the services she needs, whether or not the MHP claims to provide them.

The Department denied her request and Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in doing so.

In support of her request, Appellant testified regarding her general inability to see the specialists she needs to visit. She also points to a prescription issued by her doctor that states that Appellant has multiple medical problems and needs to have straight Medicaid due to her need to see multiple physicians. (Respondent's Exhibit A, page 19).<sup>1</sup>

Even considering that testimony and prescription, this Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the Department erred in denying her disenrollment request. Appellant has a primary care physician through [REDACTED] and the MHP also has specialists that Appellant can be referred to if necessary. Appellant's primary care physician gave no reason in the prescription as to why he cannot refer Appellant to any necessary specialists.<sup>2</sup>

Moreover, while Appellant herself generally testified that she has been unable to get the care she needs, she failed to present any evidence establishing that she is experiencing any lack of access. She could not identify any specific denials of services or referrals that she claims are necessary. She could not point to any grievances or complaints filed with [REDACTED]. There is simply no physician documentation to support an access to care or services issue or the inability of the MHP to make arrangements for care. The MHP has specialists in-network or can refer out-of-network for treatment

Appellant may desire to access Medicaid benefits through the Fee-For-Service Medicaid setting, but her preference alone is insufficient and she must meet the criteria for disenrollment for cause in this case. For the reasons discussed above, this Administrative Law Judge finds that she has been unable to do so and the Department's denial of the request for special disenrollment must therefore be upheld.

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<sup>1</sup> Appellant also provided a Medical Exception Request form signed by her doctor after the denial at issue in this case. That form also indicated that Appellant has multiple medical problems and needs to see multiple specialists. (Respondent's Exhibit A, page 9).

<sup>2</sup> According to [REDACTED], the doctor also reported that he only wrote the prescription and form submitted by Appellant because Appellant demanded that he do so. (Respondent's Exhibit A, page 25).

[REDACTED]  
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**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request to receive a Special Disenrollment-For Cause.

**IT IS THEREFORE ORDERED** that:

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

*Steven Kibit*

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Steven Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.