

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. 2013-55803 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 (Department).

ISSUE

Did the Department properly deny Appellant's request to receive a Special Disenrollment-For Cause from a Managed Care Program?

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 enrolled in ██████████, a Medicaid Health Plan ("MHP"), since ██████████. (Department Exhibit A, pages 2).
2. On ██████████, the Department received a Special Disenrollment-For Cause Request form from Appellant, stating that she was diagnosed with Myeloma and needs to see a qualified medical source who does not accept patients enrolled in ██████████ (Department Exhibit A, page 10).
3. On ██████████, the Director of Member Services from ██████████ sent the Department a response letter, stating that the MHP contacted Appellant's primary care physician, ██████████ an out-of-network provider, who is

willing to bill ██████████ for payment and will be available to treat Appellant, and Appellant was informed of this information and expressed her understanding of the MHP's out-of-network policy; Appellant declined assistance with scheduling with ██████████ and the MHP has a "robust provider network in ██████████ and there are over ██████ primary care physicians located within ██████ miles of Appellant's home address who are accepting new patients. (Department Exhibit A, page 13)

4. On ██████████ the Department sent Appellant a written denial of her Special Disenrollment-For Cause request. (Respondent's Exhibit A, page 9).
5. The ██████████ denial notice stated in pertinent part that:

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

There was no medical information provided from your doctor or access to care/services issue described that would allow for a change in health plans outside of the open enrollment period. Our records show that you have been enrolled in ██████████ since ██████████. ██████████ has several primary care providers and specialists available to treat you within their network of contracted doctors. ██████████ has advised that ██████████ has agreed to accept an out of network referral to continue to treat you and will bill the health plan for your care. You can call ██████████ at ██████████ if you have any questions, need help finding a doctor or if you need help making arrangements for specialty care or services. [Department Exhibit A, page 9]

6. On ██████████ the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing, protesting the denial.

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.

On ██████████ 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, contracts with the Medicaid Health Plan (MHP) to provide State Medicaid Plan services to enrolled beneficiaries. 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; Department Exhibit A, pages 15-18.]

In this case, the Department received Appellant's Special Disenrollment-For Cause Request, stating that she was diagnosed with Myeloma and needs to see a qualified medical source who does not accept patients enrolled in [REDACTED]

The evidence on the record establishes that the Department reviewed Appellant's Special Disenrollment-For Cause Request and contacted [REDACTED]. On [REDACTED] the Director of Member Services from [REDACTED] sent the Department a response letter, stating that the MHP contacted Appellant's primary care physician, [REDACTED] an out-of-network provider, who is willing to bill [REDACTED] for payment and will be available to treat Appellant, and Appellant was informed of this information and expressed her understanding of the MHP's out-of-network policy; Appellant declined assistance with scheduling with [REDACTED]; and the MHP has a "robust provider network in [REDACTED] [REDACTED]", and there are over [REDACTED] primary care physicians located within [REDACTED] miles of Appellant's home address who are accepting new patients.

The Department properly determined that the Appellant does not meet the for cause criteria necessary to be granted a special disenrollment. Appellant has access to primary care providers and/or necessary specialty services with [REDACTED]. Additionally, the medical doctor that Appellant would like to see for medical treatment has agreed to accept an out of network referral to continue to treat Appellant and bill [REDACTED] for Appellant's care.

Appellant can always request a change of health plans without cause and without providing documentation of reason or need during the next open enrollment period.

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 from a Managed Care Program.

IT IS THEREFORE ORDERED that:

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

Marya A. Nelson-Davis
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

[REDACTED]
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MAND/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.