

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. 2014-374 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 his 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 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 is a member of the population required to enroll in a Medicaid Health Plan ("MHP"). (Respondent's Exhibit A, page 10; Testimony of ██████).
2. Appellant has been enrolled in the MHP of ██████████ (██████████) since ██████████ (Respondent's Exhibit A, pages 13).
3. On or about ██████████ the Department's enrollment services section received a Special Disenrollment-For Cause Request from Appellant. (Respondent's Exhibit A, pages 10-12).
4. That request indicated that Appellant wanted to change health plans due to slow processing times regarding work on Appellant's prosthetic leg, even though it was requested through ██████████, a company ██████████.

works with, and denials of treatment for Appellant's gender dysphoria. (Respondent's Exhibit A, page 11).

5. The request also stated that Appellant has not filed any complaints or grievances regarding the MHP because he was afraid of retaliation. (Respondent's Exhibit A, page 11).
6. The request further stated that Appellant has never requested a hearing regarding any denial of services because he was afraid of being dropped by the MHP. (Respondent's Exhibit A, page 11).
7. The Department sent Appellant's request to ██████████ for a review and response. (Testimony of ██████████).
8. On ██████████ submitted its response to the Department. (Respondent's Exhibit A, pages 13-15; Testimony of ██████████).
9. In that response, ██████████, a representative for ██████████, wrote that she spoke with Appellant after receiving the request and learned that, in addition to wanting to switch health plans, he also wanted to switch primary care physicians. ██████████ then informed Appellant that the physician he wanted to switch to accepted ██████████ and therefore Appellant could switch primary care physicians at any time. She also informed Appellant that ██████████ has a network of doctors who can provide service for him. (Respondent's Exhibit A, page 13).
10. ██████████ response also provided that while Appellant has been denied test strips and treatment for gender dysphoria, the test strips were denied because Appellant tried to fill his prescription too soon while the treatment for gender dysphoria was denied because such treatment is not covered by the MHP. (Respondent's Exhibit A, page 13).
11. With respect to work on Appellant's prosthetic leg, ██████████ representative wrote that the only authorization request from ██████████ was submitted on ██████████ and approved on ██████████ (Respondent's Exhibit A, page 13).
12. Appellant's request and ██████████ response was reviewed by ██████████ ██████████, the Chief Medical Director for the Department's Office of Medical Affairs. (Respondent's Exhibit A, page 16; Testimony of ██████████).
13. ██████████ determined that Appellant's disenrollment request should be denied on the basis that:

There was no physician documentation to support an access of care or service issue or

the inability of the health plan to make
arrangements for care.

Respondent's Exhibit A, page 16

14. On ██████████ the Michigan Administrative Hearing System (MAHS) received a complete and signed request for hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, pages 1-2; Respondent's Exhibit A, pages 7-8).

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 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, contracts with the 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, pages 21-22¹*

Here, the Department received Appellant's Special Disenrollment-For Cause Request indicating he wants to switch from his MHP due to slow processing times regarding work on Appellant's prosthetic leg and the denial of treatment for Appellant's gender dysphoria. No other documentation was submitted along with the request.

In reviewing the Appellant's Special Disenrollment-For Cause Request, the Department contacted ██████████ and ██████████ submitted a response indicating that Appellant wanted to switch primary care physicians and was free to do so at any time; ██████████ has a network of doctors who can provide services for him or refer him out-of-network; a request for test strips was previously denied because Appellant tried to fill his prescription too soon; treatment for gender dysphoria was denied because such treatment is not covered by the MHP; and ██████████ timely approved the only request it had received regarding work on Appellant's prosthetic leg.

Subsequently, the Department 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 ██████████ and no quality of care issues were documented.

Appellant bears the burden of proving by a preponderance of the evidence that Department erred in denying his disenrollment request. In this case, for the reasons discussed below, Appellant has failed to meet that burden of proof.

As noted the Department's representative, Appellant can always request a change of health plans without cause and without providing documentation of reason or need during the next annual open enrollment.

Outside of open enrollment period, however, he must meet the criteria set forth in the contract. In short, he must establish he has been unable to access care he requires or

¹ The relevant portion of the contract was admitted as part of Respondent's Exhibit A, pages 20-21.

that he is undergoing active treatment for a serious medical condition with a doctor who does not participate in his health plan.

In this case, the evidence establishes that Appellant has access to many primary care physicians and specialty care providers through referrals to participating providers. Appellant did not present any evidence to establish he is experiencing a lack of access to care and he confirmed that has not filed any complaints, grievances or appeals against the MHP. Appellant did express a preference for the MHP he was previously enrolled in, but that is not a basis upon which special disenrollment may be granted and he not met the criteria set forth in the contract.

Appellant did testify that the ██████████ has denied him treatment for gender dysphoria, but both ██████████ and the Department have taken the position that the denial was proper and that treatment for gender dysphoria would be through Appellant's local Community Mental Health Services Provider (CMHSP) or Prepaid Inpatient Health Plan (PIHP). During the hearing, the Department's representative again referred Appellant to his CMHSP/PIHP while Appellant appeared to acknowledge that he now agreed with the MHP's position. In any event, to the extent Appellant still disagrees with that denial of treatment for gender dysphoria through the MHP, he is free to appeal the decision through the proper avenues, which he has not done previously, and that mere denial of a service is not a basis for disenrollment in this case.

Accordingly, the Department's denial of the request for special disenrollment must be upheld.

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**.

Steven Kibit

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

Date Signed: ██████████

Date Mailed: ██████████

[REDACTED]
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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.