STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 15-004794 DIS
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Medical Exception and Special Disenrollment Program Specialist, appeared and testified on behalf of the Respondent Michigan Department of Health and Human Services ("DHHS" or "Department").

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 Medicaid beneficiary who is also a member of the population required to enroll in a Michigan Medicaid Health Plan. (Testimony of Miller).

2. Appellant has been enrolled in the Medicaid Health Plan of [redacted] of Michigan[redacted] since [redacted]. (Testimony of Miller).

3. On [redacted], the Department's enrollment services section received a Special Disenrollment-For Cause Request and supporting medical documentation from Appellant. (Exhibit A, pages 8-15).

4. In that request, Appellant indicated that she wanted to switch to straight Medicaid because she cannot see her doctors at the University of Michigan unless she switches out of her plan. (Exhibit A, page 8; Testimony of Appellant).

5. Appellant also wrote that she has health conditions that need instant treatment and that being in a health plan network has severely limited her ability to see the specialists she needs to see. (Exhibit A, page 8).

6. Appellant further indicated on the form that she had not filed a complaint or grievance with her health plan or requested an administrative hearing with the Department regarding any problems with her care. (Exhibit A, page 8).

7. The Department sent Appellant's request to [redacted] for a review and response. (Testimony of Miller).

8. On [redacted] submitted its response to the Department. (Exhibit A, pages 16-17).

9. In that response, [redacted] indicated that it had been unable to contact Appellant, but it had located specialists and primary care providers in Appellant's area that were accepting new patients and that it would send her a list. (Exhibit A, pages 16-17).

10. On [redacted], the Department sent Appellant written notice that her Special Disenrollment-For Cause Request was denied. (Exhibit A, page 7).

11. With respect to the reason for the denial, the notice stated:

> 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 a change to Fee-For-Service (FSS) Medicaid. Our records show that you have enrolled in Mol[redacted] since [redacted]. [redacted] has several primary care providers and specialists available to treat you within their network of contracted doctors. If medically necessary and appropriate, your doctors can refer you out of network to the University of Michigan specialists. You and your doctors can work with the health plan on the referral process and it the request is denied you can ask for a hearing with the plan on that issue.

Exhibit A, page 6

12. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Exhibit A, page 6).

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 statutes, 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 Health and Human Services, pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with the health plans to provide State Medicaid Plan services to enrolled beneficiaries. The Department's contract with the health plan 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.
>
> *Exhibit A, pages 22-23*

Here, the Department received Appellant's Special Disenrollment-For Cause Request indicating that the Appellant wanted to change to FFS Medicaid because the specialists she wishes to use are not part of Molina's network of providers.

In reviewing the Appellant's Special Disenrollment-For Cause Request, the Department contacted Molina for a review and the health plan submitted its response to the Department. In that response, Molina wrote that it was unable to contact Appellant, but that it has primary care providers and specialists available to treat the Appellant within their network of contracted doctors.

Subsequently, the Department determined that the Appellant did not meet the for cause criteria necessary to be granted a special disenrollment, because there was no medical information provided from the Appellant or her doctor demonstrating access to care/services issue or concerns with quality of care that would allow for a disenrollment from her health plan.

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

As noted by 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 period, which in this case is [redacted].

Outside of open enrollment period, however, she must meet the criteria set forth in the contract. In short, she must establish she has been unable to access care she requires, demonstrate concerns with quality of care, or establish that she is undergoing active treatment for a serious medical condition with a doctor who does not participate in her health plan.

In this case, the Appellant did not present any such evidence and her request is based merely on the fact that she wants to be treated by certain specialists or have the flexibility to get care wherever she wants without going through a referral process or having to work within a network. However, that preference and a desire for flexibility is insufficient to demonstrate cause for disenrollment where her health plan has primary care providers and specialists available to treat the Appellant within their network of contracted doctors; her doctors could refer her to out-of-network specialists when necessary and appropriate; and Appellant has never filed a complaint or grievance with her health plan or requested an administrative hearing with the Department regarding any problems with her care. 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.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK[redacted]

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.