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. 15-006810 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 June 17, 2015. 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 and a member of the population required to enroll in a Medicaid Health Plan ("MHP"). (Testimony of [redacted]

2. Appellant has been enrolled in the MHP of [redacted] ("[redacted] since [redacted]. (Testimony of Miller).

3. On [redacted], the Department received a Special Disenrollment-For Cause Request from Appellant. (Exhibit A, pages 7-8).

4. In that request, Appellant indicated that she would like to change to the MHP of [redacted] or [redacted] because she is having issues getting her medications filled and the only pain specialist who has been helping her no longer accepts [redacted] (Exhibit A, page 7).

5. Appellant also 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 7).

6. Along with the disenrollment request, Appellant submitted a [redacted] letter from a [redacted] and [redacted] in which the medical providers indicated that, as of [redacted], they were no longer accepting Molina. (Exhibit A, page 8).

7. The medical providers also indicated what Medicaid insurance plans they did accept: [redacted]; [redacted]; and Straight Medicaid. (Exhibit A, page 8).

8. The Department sent Appellant's request to Molina for a review and response. (Testimony of Miller).

9. On [redacted], Molina submitted its response to the Department. (Exhibit A, pages 9-10).

10. In that response, [redacted] indicated that Appellant has called several times regarding prescriptions and [redacted] staff either explained the prior authorization process to her or advised her of what steps her doctor needed to do to get the requested medications or alternative drugs approved. (Exhibit A, page 9).

11. [redacted] also indicated in its response that it has confirmed that [redacted] office is no longer accepting [redacted] but that it had located two other facilities that have pain management doctors and that accept Molina. (Exhibit A, pages 10-11).

12. That same day, [redacted] also sent Appellant a list of the two facilities it has identified. (Exhibit A, pages 11-12).

13. On [redacted], the Department sent Appellant written notice that her Special Disenrollment-For Cause Request was denied. (Exhibit A, page 6).

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

> Your request has been denied for the following reason(s):
>
> The information from your doctor only listed what insurances they work with; it did not describe active treatment for a serious medical condition. There was no access to care 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 Molina Healthcare of Michigan since 05/01/2013. All of the health plans have prior authorization (PA) processes for some prescription medications. If your doctor believes you need a medication that is not on the preferred drug list, they can send in a PA and, if that request is denied, you and/or your doctor can file an appeal or hearing against the health plan on that denial. This is not a reason to change health plans. Molina Healthcare of Michigan has several primary care providers and specialists, including pain management providers, available to treat you within their network of contracted doctors. You can call Molina Healthcare of Michigan at 1-888-898-7969 if you have any questions, need help in finding a doctor or if you need help making arrangements for specialty care or services.
>
> *Exhibit A, page 6*

15. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Exhibit A, page 5).

16. On [redacted], an administrative hearing was held.

17. During that hearing, Appellant testified that she no longer wished to switch MHPs and, instead is only interested in Straight Medicaid. (Testimony of Appellant).

18. Appellant also testified that her request is based solely on her desire to remain with the doctor who has successfully treated her in the past and that she is not having problems with medications. (Testimony of Appellant).

19. Appellant further testified that she has been trying to find a new doctor through [redacted] but has been unsuccessful. (Testimony of Appellant).

20. Appellant has not contacted [redacted] about her difficulties. (Testimony of Appellant).

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 [redacted], 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
>
> (1) Medical Exception
>
> The beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the Contractor at the time of the enrollment. The beneficiary must submit a medical exception request to DCH.
>
> (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 MHPs. However, during the hearing, Appellant testified that she no longer wanted to switch MHPs and, instead, wanted to enroll in Straight/Fee-For-Service Medicaid because her pain specialist no longer accepts Molina.

With respect to that issue, [redacted] response to the Department indicated that it had confirmed that [redacted] office no longer accepts [redacted] but that it had also located two other facilities that have pain management doctors and that accept [redacted]

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's doctor indicating an active treatment for a serious medical condition, access to care/services issues, or concerns with quality of care, that would allow for a change in health plans outside of the open enrollment period.

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 October of 2015.

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, Appellant did not present any such evidence and her request is based merely on the fact that she wants to be treated by his former pain specialist, who no longer accepts [redacted] However, that mere preference for a particular doctor is insufficient to demonstrate cause for disenrollment where Appellant has failed to present any evidence establishing that she is undergoing active treatment for a serious medical condition with that doctor or that her health plan does not have primary care providers and specialists available to treat the Appellant within their network of contracted doctors. Appellant did testify that she has unsuccessfully attempted to locate a doctor through [redacted] but she also failed to support that testimony with any other evidence and it is undisputed that she never contacted Molina about any difficulties or attempted to work with that MHP. 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/hj

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.