[redacted]
[redacted] MI [redacted]

Date Mailed: February 25, 2025
MOAHR Docket No.: 24-012487
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Steven Kibit**

## DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed on behalf of Petitioner Aerilyn Bunnell (Petitioner).

After due notice, a telephone prehearing conference was held on December 10, 2024. [redacted] the minor Petitioner's mother, appeared on Petitioner's behalf. No one appeared for either of the Medicaid Health Plans (MHPs) identified as Respondents, AmeriHealth Caritas and Blue Cross Complete of Michigan (BCC).

During the conference, Petitioner's representative and the undersigned ALJ discussed the issues on appeal and who the proper parties were. It was also determined that another telephone prehearing conference would be held, with a representative for the Michigan Department of Health and Human Services (MDHHS or Department) added to the case.

After due notice, a second telephone prehearing conference was held on January 7, 2025. Petitioner's mother again appeared on Petitioner's behalf. Mark Diaz, Manager of Member Grievances, appeared on behalf of both BCC and AmeriHealth Caritas, confirming on the record the relationship between those entities. Several other people from BCC were also present. Karen Miller, Disenrollment Specialist, and Jennifer Bauman, Policy Specialist, appeared on behalf of the Department, with Lisa Langdon, Department Manager, and Caitlin Conroy, Nurse Consultant, also present for the Department.

During the conference, the parties and undersigned ALJ discussed the history of Petitioner's case and the issues on appeal. In particular, the ALJ determined that two types of issues were properly before him, with BCC the Respondent for all of them. The two types of issues were alleged denials of medical services and non-emergency medical transportation. Petitioner and BCC also agreed to work together what specific claims for medical services were at issue.

The ALJ further determined that Petitioner's other complaints or grievances did not fall within his jurisdiction. The ALJ also found that the Department should be dismissed as a party in this matter as Petitioner had no claims before it.

On January 10, 2025, the ALJ issued an Order with the above findings and a Notice of Hearing scheduling a telephone hearing for February 6, 2025.

On January 15, 2025, Petitioner filed a Request for Reconsideration. In that request, amongst claims that Petitioner's rights have been violated, she has been discriminated against, and the ALJ engaged in inappropriate conduct, Petitioner's representative also appeared to request that the decision to dismiss the Department as a party and the findings regarding what issues are within the ALJ's jurisdiction be reconsidered in light of Petitioner's arguments. Petitioner further requested that the hearing be conducted virtually and, rather than require Petitioner to submit subpoena requests, the ALJ order the attendance of witnesses.

On January 24, 2025, the ALJ issued an Order and Notice of Hearing denying both Petitioner's request for reconsideration, for essentially the same reasons her earlier requests had been denied, and her request for an order regarding witnesses, for a lack of good cause. The ALJ did grant Petitioner's request for a virtual hearing, and the telephone hearing scheduled for February 6, 2025 was converted into a hearing via video conferencing.

On February 6, 2025, the hearing via video conferencing was held and completed as scheduled. [redacted] the minor Petitioner's mother, appeared and testified on Petitioner's behalf. Attorney Toby Eveland represented the Respondent BCC (Respondent). Courtney Cloutier, Compliance Director, and Dena Austin, Director for Care Management, testified as witnesses for Respondent.

During the hearing, Petitioner submitted forty-one proposed exhibits that were admitted into the record without objection as Exhibits #1 - #41.[1] Respondent also submitted eight proposed exhibits that were admitted into the record without objection as Exhibits A – H.

## ISSUES

Did Respondent improperly deny claims or services related to medical services or non-emergency medical transportation?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a [redacted] year-old Medical beneficiary who has been diagnosed with, among other conditions, autism spectrum disorder; seizures, DiGeorge syndrome; developmental delays; other primary disorders of muscles; obstructive sleep apnea; myoclonus; a heart murmur; hypotonia; urinary tract infections; constipation; and feeding issues. (Exhibit #4, page 34; Exhibit #8, pages 58-66).

[1] Petitioner's exhibits, outside of the audio recordings, are numbered collectively as pages 1-216, and the ALJ will refer to those stamped page numbers for ease of convenience in this Decision and Order.

2. On August 9, 2024, and September 9, 2024, the Department sent Petitioner's representative a Health Care Coverage Determination Notice stating that, effective October 1, 2024, Petitioner was not eligible for Medicaid. (Exhibit #5, pages 36-39; Exhibit #6, pages 41-45).

3. Due to the notices indicating that Petitioner was losing Medicaid coverage, her parents enrolled her in her father's insurance plan, Blue Cross Blue Shield of Michigan (BCBSM), with a start date of October 1, 2024. (Exhibit #12, page 80; Testimony of Petitioner's representative).

4. Petitioner's representative had also applied for the Home Care Children's (HCC)/ Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Program for Petitioner at an earlier time. (Exhibit #3, page 32; Exhibit #7, pages 49-56).

5. On September 24, 2024, the Department sent Petitioner's representative written notice that Petitioner had been clinically approved for enrollment into the HCC Program. (Exhibit #10, pages 70-74).

6. The notice also provided that, to complete enrollment process, a Medicaid financial determination must be completed. (Exhibit #10, page 70).

7. As part of the HCC Program, Petitioner was to disenroll from any private insurance plan and enroll in a Medicaid Health Plan (MHP), a type of Managed Care Organization (MCO), such as Respondent. (Exhibit #12, pages 79-81).

8. On October 7, 2024, the Department sent Petitioner's representative a Health Care Coverage Determination stating that Petitioner had been approved for full Medicaid coverage as of October 1, 2024. (Exhibit #14, page 103).

9. On October 14, 2024, Petitioner was fully approved for the HCC program, with a retroactive start date of October 1, 2024. (Exhibit #12, page 81).

10. Petitioner's representative was also able to end Petitioner's private insurance as of October 1, 2024, the date it was supposed to start. (Exhibit #12, page 83).

11. Petitioner further enrolled in Respondent as her MHP. (Exhibit #12, page 80-83).

12. On October 25, 2024, Michigan ENROLLS sent a letter confirming Respondent as Petitioner's MHP choice, though with an effective start date of December 1, 2024. (Exhibit #20, page 121).

13. On October 30, 2024, Petitioner's representative sent an email to the Department indicating that she was having issues establishing Petitioner's correct enrollment status. (Exhibit #21, pages 125-126)

14. For example, while Petitioner's coverage was, or should have been, active as of October 1, 2024, her representative was initially unable to access or receive mileage reimbursement for non-emergency medical transportation. (Exhibit #21, page 126-128; Testimony of Petitioner's representative).

15. Petitioner's representative subsequently worked with the Department and Modivcare, a transportation vendor, to resolve mileage reimbursement issues. (Exhibit #22, pages 130-131; Testimony of Petitioner's representative).

16. No claims for mileage reimbursement were submitted to Respondent in October or November of 2024. (Testimony of Compliance Director).

17. Petitioner's representative was billed directly for claims related to medical services where the claims were submitted to, and denied, by BCBSM. (Exhibit #31, pages 162-164).

18. On November 15, 2024, MOAHR received a request for hearing filed in this matter.

19. On November 18, 2024, Petitioner's representative also filed a complaint with the Department. (Exhibit #35, page 189).

20. Beginning December 4, 2024, Respondent began paying claims submitted on Petitioner's behalf for dates of services beginning October 1, 2024. (Exhibit E, pages 5-8; Testimony of Compliance Director).

21. One claim for $4,955.00, with a date of service of October 2, 2024, had been initially denied on the basis that Petitioner had primary coverage through BCBSM, but Respondent's Third Party Liability (TPL) department subsequently reviewed the request and approved payment. (Exhibit D, page 2; Exhibit E, page 5; Testimony of Petitioner's representative; Testimony of Compliance Director).

22. On December 5, 2024, Petitioner's representative further filed a complaint with the Department of Insurance and Financial Services (DIFS) regarding both Respondent and BCBSM. (Exhibit #33, pages 169-170).

23. On December 10, 2024, Petitioner's representative also filed a grievance with Respondent. (Exhibit #40, page 211).

24. Petitioner's representative filed additional grievances with Respondent after December 10, 2024, as well. (Exhibit #40, pages 213-214; Testimony of Petitioner's representative).

25. On December 19, 2024, Respondent received requests for mileage reimbursement submitted on Petitioner's behalf through Modivcare. (Exhibit #38, pages 199-200; Exhibit #39, page 205).

26. On December 20, 2024, Respondent filed a response with DIFS regarding Petitioner's representative's complaint. (Exhibit D, pages 1-3).

27. As part of that response, Respondent provided a list of all claims it had received since October 1, 2024. (Exhibit D, pages 1-3; Testimony of Compliance Director).

28. On January 7, 2025, Petitioner's representative submitted mileage reimbursement requests for the period of December 19, 2024, to January 7, 2025. (Exhibit #38, pages 201-202).

29. On January 7, 2025, during the Second Telephone Prehearing Conference, Respondent agreed to provide Petitioner's representative with a list of claims that had been submitted to it, so that Petitioner's representative could determine what, if anything, remained in dispute. (Exhibit #39, pages 204-209; Exhibit B, pages 1-6).

30. On January 8, 2025, Respondent sent Petitioner's representative a list of claims received after December 10, 2024. (Exhibit #40, page 213).

31. On January 9, 2025, in response to a request from Petitioner's representative for a list of all claims since October 1, 2024 ongoing, Respondent provided Petitioner's representative with a list of claims for Dates of Service between October 1, 2024, and January 7, 2025. (Exhibit #40, pages 213-214; Exhibit E, pages 1-10; Testimony of Compliance Director).

32. On January 30, 2025, Respondent sent Petitioner a response to a grievance filed on January 7, 2025, regarding finding a primary care physician and transportation reimbursement. (Exhibit F, pages 1-14).

33. As part of that response, Respondent identified mileage reimbursements processed as part of the check run on January 10, 2025, for dates of services between November 20, 2024, and January 7, 2025. (Exhibit F, pages 1-14).

34. Respondent also subsequently sent Petitioner's representative an update regarding mileage reimbursement, which an indication that $479.72 would be paid out as part of the next check run, scheduled for February 7, 2025, for dates of service between October 2, 2024 and November 21, 2024. (Exhibit H, page 1).

## CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

Here, Petitioner has been approved for Medicaid coverage through the Home Care Children (HCC) Program and Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which added a provision to Title XIX of the Social Security Act expanding Medicaid coverage to children with a medical institution level of care need who are living at home and would otherwise be ineligible for Medicaid due to a higher family income. *See* Bridges Eligibility Manual (BEM) 170.

Through HCC/TEFRA, Petitioner has been approved for Medicaid and enrolled with Respondent, a Medicaid Health Plan (MHP) responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> *MPM, October 1, 2024 version*
> *Medicaid Health Plans Chapter, page 1*

In this administrative proceeding involving Petitioner and her MHP, the undersigned ALJ will first reiterate his earlier rulings regarding the scope of his jurisdiction as a preliminary matter.

Pursuant to 42 CFR 438.400 and 42 CFR 438.402, a Managed Care Organization (MCO) such as Respondent must have a grievance and appeal system in place for enrollees such as Petitioner, with an appeal meaning a review by Respondent of an adverse benefit determination and a grievance meaning an expression of dissatisfaction about any matter other than an adverse benefit determination. Moreover, it is only after an appeals process is exhausted or deemed exhausted with respect to an adverse benefit determination that an enrollee may request a State fair hearing like the one requested in this case. *See* 42 CFR 438.408(f).

In the case of an MCO, an adverse benefit determination means any of the following:

> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
>
> (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

*42 CFR 438.400(b)*

Conversely, grievance is defined as follows:

> *Grievance* means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

*42 CFR 438.400(b)*

Accordingly, given the limitation on the basis for requesting a State fair hearing, many of Petitioner's complaints or requests involving Respondent are beyond the scope of the undersigned ALJ's jurisdiction.

Petitioner's dissatisfaction with the quality of Respondent's services or requests for remedies to address any deficiencies, such as providing a case manager, help in finding a primary care physician and a request for a new Medicaid ID number, are grievances that do not give rise to the right to a State fair hearing. Moreover, while Petitioner's representative testified that Respondent's handbook provides that Petitioner can request a hearing to address her grievances, that testimony is unsupported[2] and, regardless, any such provisions in the handbook would be incorrect. The sole jurisdiction that the undersigned ALJ could have with respect to grievances is whether Respondent failed to act within the required timeframes regarding the standard resolution of grievances, 42 CFR 438.400(b)(5), but that is not the case here; where the grievances were responded to and Petitioner wants the merits of her grievances addressed.

Similarly, to the extent Petitioner's representative wants information in order to understand any past issues and prevent future issues, her requests are not adverse benefit determinations that provide jurisdiction in this case. Petitioner's representative's concerns are valid and understandable, but this administrative proceeding is not the proper forum for them.

With respect to the two types of issues that could involve adverse benefit determinations, *i.e.,* alleged denials of medical services and mileage reimbursement for non-emergency medical transportation, Petitioner has the burden of proving by a preponderance of the evidence that the MHP erred.

Given the above policy and evidence in this case, Petitioner has failed to satisfy her burden of proof, and that Respondent's actions must therefore be affirmed.

For example, while Petitioner filed a request for hearing on November 15, 2024, alleging in part that Respondent had been denying medical services despite Petitioner being enrolled with it since October 1, 2024, Petitioner has failed to demonstrate any improper denials or constructive denials of medical services still at issue from the relevant time period.[3]

It is undisputed that a claim for $4,955.00, with a date of service of October 2, 2024, was initially denied by Respondent on the basis that Petitioner had primary coverage through BCBSM. However, it is also undisputed that Respondent's TPL department subsequently reviewed the claim and approved payment.

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[2] Respondent did provide general information on grievances, appeals and external reviews, whether through DIFS and/or a State fair hearing, as part of its responses to Petitioner's grievances. *See* Exhibit E; Exhibit F. However, those responses do not confer jurisdiction in this case.

[3] During the second telephone prehearing conference, Petitioner's representative identified a denial/adverse benefit determination that occurred long after the request for hearing in this case was filed, but the ALJ determined that any request for hearing on that specific determination is premature. Petitioner must first appeal that action with Respondent and, if the appeal upholds the ABD, she can then file a request for State fair hearing. *See* 42 CFR 438.499 *et seq.*

Moreover, while Petitioner's representative testified that there is a claim that a provider reported to her that has been made, but not paid out, Petitioner's representative's testimony is unsupported; lacks detail, with Petitioner's representative unaware of how much the claim was for or when it was sent; and is contradicted by Respondent's Compliance Director's credible testimony.

Petitioner's representative also testified that she has been billed personally for services that should have been covered by Respondent. However, Petitioner's own Exhibit #31 demonstrates that Petitioner's representative was billed after BCBSM denied coverage, not Respondent. If the provider mistakenly submitted claims to BCBSM rather than Respondent, then there is no denial by Respondent, which cannot process claims unless submitted to it.

Rather than identifying any denied claims still at issue, Petitioner's representative primarily testified that she cannot be sure what claims are still out there because she is having issues accessing Petitioner's online account with Respondent. However, any such difficulty alone does not meet Petitioner's burden of proof or demonstrates any improperly denied claims. Respondent's Compliance Director also testified that Respondent provided a list of claims that it has paid as part of its exhibits.

Similarly, with respect to requests for mileage reimbursement for non-emergency medical transportation, Petitioner has failed to demonstrate any improper denials still at issue from the relevant time period.

It does appear that, as credibly testified to by Petitioner's representative, there was a period when Petitioner was unable to access mileage reimbursement due to issues and confusion regarding Petitioner's enrollment status. However, there is no evidence that any actual claims were submitted to, or denied, by Respondent.

Moreover, any previous issues with requesting mileage reimbursement that could possibly be deemed constructive denials are now legally moot given that it is undisputed that, since Petitioner filed the request for hearing in this case, claims for mileage reimbursement have been submitted and reimbursed.

Respondent's Compliance Director further credibly testified that all remaining claims have been processed and will be paid soon; and, while Petitioner's representative testified that she cannot be sure that all claims have been paid or processed given a lack of information, she failed to identify any specific claim for mileage reimbursement that has not been processed and remains in dispute.

Both parties indicated that they are working together with respect to both mileage reimbursement and medical services, but to the extent that Respondent does deny any claims in the future, Petitioner can appeal that denial with Respondent and, if the adverse benefit determination is upheld, file a request for State fair hearing.

However, at this time, Petitioner has failed to demonstrate any error with respect to any remaining disputed claims, and her request for hearing must therefore be dismissed.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Petitioner has failed to meet her burden of proof, with her claims either outside of the scope of this proceeding, legally moot, or unsubstantiated.

**IT IS, THEREFORE, ORDERED** that:

Respondent's decisions are **AFFIRMED**.

SK/sj

Steven Kibit

**Steven Kibit**
Administrative Law Judge

**NOTICE OF APPEAL**: Petitioner may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

**PROOF OF SERVICE**

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 25th day of February 2025.

S. James
**Michigan Office of Administrative Hearings and Rules**

**Via Electronic & First Class Mail:**

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