STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2011-11892 MCE
Case No. 40191408

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.*, upon the Appellant's request for a hearing appealing the Department's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held [redacted]. [redacted] the Appellant, appeared on her own behalf. [redacted] represented the Department. [redacted] appeared as a witness for the Department.

ISSUE

Does the Appellant meet the requirements for a managed care exception?

FINDINGS OF FACT

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

1. The Appellant is [redacted] Medicaid beneficiary. (Exhibit 1, page 8)

2. The Appellant resides in [redacted] Michigan. She is a member of the population required to enroll in a Medicaid Health Plan (MHP). ([redacted] Testimony)

3. The Appellant remains enrolled in Fee-For-Service or straight Medicaid pending the outcome of this appeal. [redacted]

Testimony)

4. On [redacted], the Michigan Department of Community Health Enrollment Services Section received a managed care exception request filed on the Appellant's behalf by the [redacted]. (Exhibit 1, page 8)

5. On [redacted], the Appellant's request for a managed care exception was denied. The denial notice indicated that the medical documentation submitted did not show active treatment for a serious problem as the law requires. The notice specified that the doctor stated the Appellant's condition(s) are chronic and stable. (Exhibit 1, page 9)

6. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's request for an Administrative Hearing. (Exhibit 1, page 7)

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.

Michigan Public Act 131 of 2009 states, in relevant part:

> Sec. 1650 (3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to mandatory enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

MDCH Medicaid Provider Manual, Beneficiary Eligibility Section, October 1, 2010, page 31, states in relevant part:

> The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an

> attending physician (M.D. or D.O.) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:
>
> - The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
> - The condition stabilizes and becomes chronic in nature, or
> - The physician becomes available to the beneficiary through enrollment in a MHP.
>
> If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

MDCH Medicaid Provider Manual, Beneficiary Eligibility Section, October 1, 2010, pages 31-32, states in relevant part:

> **Serious Medical Condition**
>
> Grave, complex, or life threatening
>
> Manifests symptoms needing timely intervention to prevent complications or permanent impairment.
>
> An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.
>
> **Chronic Medical Condition**
>
> Relatively stable
>
> Requires long term management
>
> Carries little immediate risk to health
>
> Fluctuates over time, but responds to well-known standard medical treatment protocols.

Active treatment

Active treatment is reviewed in regards to intensity of services when:

- The beneficiary is seen regularly, (e.g., monthly or more frequently,) and
- The condition requires timely and ongoing assessment because of the severity of symptoms and/or the treatment.

Attending/Treating Physician

The physician (M.D. or D.O.) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.

MHP Participating Physician

A physician is considered participating in a MHP if he is in the MHP provider network or is available on an out-of- network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with the MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.

The Appellant's request for a medical exception indicates she is receiving treatment with monthly office visits for chronic and ongoing medical conditions including severe bipolar now well controlled, chronic back pain well controlled, and fibromyalgia relatively well controlled. (Exhibit 1, page 8)

In reviewing the Appellant's medical exception request, the Department considers three criteria as defined in the above cited policy: (1) whether there is a serious medical condition, (2) that is being actively treated, (3) by a physician who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception request indicates that the Appellant sees her doctor monthly, and he works with straight Medicaid. (Exhibit 1, page 8) However, the Department determined that based on the documentation submitted, the Appellant has chronic ongoing medical conditions rather than a serious medical condition. ([redacted] Testimony) Further, the Department witness explained that mental health coverage is outside of the Medicaid Health plans and would be covered by Community Mental Health. [redacted] Testimony)

The Appellant disagrees with the Department's denial of the medical exception request. The Appellant testified that her request for a medical exception was granted last year and she did not understand why it is being denied this year. (Appellant Testimony) The [redacted] explained that the records show last year her doctor provided documentation indicating that the Appellant was having an acute exacerbation, therefore a complete work up, testing and treatments were needed at that time. This year, the Appellant's doctor stated that the Appellant's conditions were well controlled and the treatment plan is to continue medications. Accordingly, at the time of the current medical exception request, the Appellant's medical conditions are considered chronic rather than serious under the Department policy. ([redacted] Testimony and Exhibit 1, page 8)

The Appellant's representative testified that it is hard to find a doctor to take over treatment and explained that she is on multiple medications. The Appellant also believes her conditions are getting worse. (Appellant Testimony) The [redacted] testified that there are two Medicaid Health Plans available in the Appellant's county and both have primary care doctors. The [redacted] explained that the Appellant would still have access to Medicaid covered services, including testing and treatments, in a Medicaid Health Plan. ([redacted] Testimony)

While this ALJ sympathizes with the Appellant's circumstances, the submitted documentation does not establish that the Appellant has a serious medical condition as defined in the above cited Medicaid policy. Rather, the documentation from her doctor indicates chronic conditions that are well controlled. (Exhibit 1, page 8) Accordingly, the Appellant does not meet all the criteria necessary to be granted a managed care exception.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant does not meet the criteria for Medicaid managed care exception.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

[redacted]
Docket No. 2011-11892 MCE
Decision and Order

[redacted]

Date Mailed: 3/17/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.