

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2011-46093 ABW
Case No. [REDACTED]

[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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [REDACTED] appeared on his own behalf. [REDACTED], RN, Department Manager represented [REDACTED] a County-Administered Health Plan (CHP).

ISSUE

Did the County Health Plan properly deny Appellant's prior authorization requests for Hydroxyurea?

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 enrolled in the County Health Plan (CHP) as an Adult Benefit Waiver (ABW) beneficiary.
2. Appellant is a [REDACTED] year-old male.
3. The CHP has a grant agreement with the Michigan Department of Community Health (MDCH) to provide services covered by the Adult Benefits Waiver program. The agreement under paragraph 7(b) gives the CHP flexibility to develop its own preferred drug lists and prior authorization requirements. (Exhibit C).
4. [REDACTED] administers the CHP for [REDACTED] and provides services through the [REDACTED] which has a preferred drug list and therapeutic drug formulary. (Exhibit B).
5. Appellant's physician, [REDACTED], wrote a prescription for Hydroxyurea for Appellant and Appellant's family doctor [REDACTED]

- ██████████ endorsed Appellant's need for the Hydroxyurea. (Exhibits 2, 4-6).
6. On ██████████ sent a letter indicating that they denied Appellant's request for Hydroxyurea, because the requested medication is a non-formulary, i.e. not on the list of drugs covered under this limited plan. (Exhibit 3).
 7. On ██████████, the Department of Community Health (DCH) received the Appellant's request for an Administrative Hearing. (Exhibit 1).
 8. On ██████████, the Department took action pursuant to their agreement with MDCH and notified the Appellant that his request for Hydroxyurea was denied. (Exhibit A).

CONCLUSIONS OF LAW

On January 16, 2004, the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.

The Department's policy with regard to the Adult Benefits Waiver is found in the Medicaid Provider Manual:

SECTION 1 - GENERAL INFORMATION

This chapter applies to all providers.

The Adult Benefits Waiver (ABW), provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.

SECTION 1.1 - COUNTY ADMINISTERED HEALTH PLANS

ABW beneficiaries enrolled in CHPs are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW

beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services as noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:

- Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable copayments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual.

*Medicaid Provider Manual, Adult Benefits Waiver,
July 1, 2011, p. 1.*

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service Coverage

- **Ambulance** Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).
- **Case Management** Noncovered
- **Chiropractor** Noncovered
- **Dental** Noncovered
- **Emergency Department** Covered per current Medicaid policy. For CHPs, PA may be required for

nonemergency services provided in the Emergency Department.

- **Eyeglasses** Noncovered
- **Family Planning** Covered. Services may be provided through referral to local Title X designated Family Planning Program.
- **Hearing Aids** Noncovered
- **Home Health** Noncovered
- **Home Help (personal care)** Noncovered
- **Hospice** Noncovered
- **Inpatient Hospital** Noncovered
- **Lab & X-Ray** Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.
- **Medical Supplies/Durable Medical Equipment (DME)** Limited coverage.
 - Medical supplies are covered except for the following noncovered categories:
 - gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item.
 - DME items are noncovered except for glucose monitors.
- **Mental Health Services** Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
- **Nursing Facility** Noncovered
- **Optometrist** Noncovered
- **Outpatient Hospital (Nonemergency Department)** Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A \$3 copayment for professional services is required. *
- Noncovered: Therapies, labor room and partial hospitalization.
- **Pharmacy**
Covered:
 - Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or oral-maxillofacial surgeon. PA may be required. Products must be billed to MDCH or CHP, as appropriate.
 - Psychotropic medications are provided under the FFS benefit. (Refer to the MDCH Pharmacy

Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. Refer to the Directory Appendix for website information.) The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently.

Noncovered: Injectable drugs used in clinics or physician offices.

Copayment: \$1 per prescription

*Medicaid Provider Manual, Adult Benefits Waiver,
July 1, 2011, Pages 4-5.*

██████████ the CHP representative explained that Appellant is an ABW beneficiary enrolled in the CHP. The CHP provides its services through the ██████████. According to the agreement between MDCH and the CHP, the CHP has flexibility to develop its own preferred drug lists and prior authorization requirements. (Exhibit C). ██████████ testified that Appellant was on a program with limited benefits and the requested medication, Hydroxyurea, is a nonformulary, that is, Hydroxyurea is not a covered medication under the plan. (Exhibit B).

The Appellant testified that his physician prescribed Hydroxyurea to treat his polycythemia. After being denied the drug by ██████████ Appellant was able to get a month and a half supply of the Hydroxyurea through ██████████ for ██████████.

The CHP denial of Hydroxyurea is consistent with Medicaid policy. ABW beneficiaries enrolled in CHPs are subject to the requirements of the respective CHP. In this case the agreement between MDCH and the CHP provided flexibility for the CHP to develop its own preferred drug lists. The CHP contracted with ██████████ and as such was following the formulary or list of covered drugs from ██████████. Hydroxyurea is not a covered medication under the Midwest preferred drug list.

The CHP and this Administrative Law Judge are bound by Department Medicaid policy, and the grant agreement between the CHP and MDCH, neither party can over-rule state and federal law and policy. As such, the CHP is not required to provide coverage for a Hydroxyurea. For the foregoing reasons the CHP's denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the County Health Plan properly denied Appellant's request for Hydroxyurea.

[REDACTED]
Docket No. 2011-46093 ABW
Decision and Order

IT IS **THEREFORE ORDERED** THAT:

The County Health Plan's decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 8/24/2011

***** 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.