

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

IN THE MATTER OF:

██████████,

Appellant

_____ /

Docket No. 2012-47368 MCE
Case No. ██████████

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 appealing the Department of Community Health (Department's) denial of an exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held ██████████ appeared on behalf of the Appellant. The Appellant's ██████████ were present. ██████████, the Appellant's Supports Coordinator, was present. The Appellant was not present. ██████████, Medical Exception Specialist/MDCH/MSA represented the Department. She had no witnesses.

The Appellant filed her hearing request ██████████. The Department sent a Denial Notice to the Appellant ██████████. Her request for hearing is treated as addressing both denials. Both Department determinations are addressed in this Decision and Order.

ISSUE

Did the Department properly deny the Appellant's request for exception from Managed Care Program enrollment?

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 a ██████████ Medicaid beneficiary. ██████████
2. The Appellant resides in ██████████. She is included in the mandatory population to enroll in a Medicaid Health plan.

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3. The Appellant has had Medical Exception Requests granted in the past, thus has not enrolled in a Medicaid Health Plan despite having been an eligible Medicaid beneficiary since [REDACTED].
4. On [REDACTED], the Michigan Department of Community Health Enrollment Services Section received [REDACTED] managed care exception request forms from the Appellant's doctors, [REDACTED].
5. [REDACTED] completed Medical exception request forms and submitted them [REDACTED].
6. [REDACTED] is a primary care provider with McLaren Health Plan, a plan available to the Appellant. [REDACTED].
7. [REDACTED] are all specialists who accept referrals from the health plans, including McLaren Health Plan. [REDACTED].
8. On [REDACTED] the Appellant was notified her request for a managed care exception on [REDACTED] was denied. The Department sent the Appellant written notice that her request was denied. [REDACTED].
9. On [REDACTED] the Appellant was notified her request for managed care exception on [REDACTED] was denied. A Notice of Denial was sent to her. [REDACTED].
10. On [REDACTED], the Michigan Administrative Hearing System received the Appellant's request for an administrative hearing. Her hearing request is treated as addressing both denials. Both denials are addressed in this Decision and Order. [REDACTED].
11. On [REDACTED] the Appellant's request for Managed Care Exception was reviewed by MSA Chief Medical Officer, [REDACTED]. [REDACTED] agreed with the Department decision to deny the Appellant's managed care exception requests. [REDACTED].

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.

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On ██████████, 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.

The Medicaid Provider Manual (MPM), Beneficiary Eligibility §9.3, January 1, 2012, 2010, page 37, states:

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 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.

The MPM also states at pp. 37-38:

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 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

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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 undisputed evidence shows that the Appellant has a serious medical condition as set forth in the above referenced portion of the Medicaid Provider Manual. She has had her requests for medical exception granted in the past. Her primary care provider, ██████████ was not a participating provider in the past. When the Appellant's providers submitted requests on her behalf this year the Department determined she was no longer eligible because her primary care physician is a participating provider. He is able to make referrals to specialists as needed for the Appellant's care. The remaining ██████ doctors who submitted the requests are participating specialists who accept referrals from Medicaid Health plans, including McLaren Health Plan. This plan is also accepted by ██████████


██████████ testified for the Department that the Appellant's exception from managed care must meet three criteria to obtain Department approval. The Appellant does have a serious medical condition. It is not in dispute. She does fail to continue to qualify for the exception because all the doctors who requested the exception on her behalf participate with at least one of the health plans available to her either as a primary care doctor or a specialist who accepts referrals from health plans. Because the Appellant no longer meets all 3 of the criteria, the Department denied all the requests for medical exception.

The Appellant did not contest the Department's evidence. Her representative stated the Appellant is seeking the exception to have maximum flexibility in seeking the needed medical treatment. She does not want to have to obtain a referral prior to seeking necessary medical treatment.

The stated reason for seeking the medical exception is not on the qualifying criteria the Department may consider. Therefore the Department properly concluded that the Appellant is not eligible for an exception from managed care. The Appellant has a full range of Medicaid covered services available to her through her Medicaid Health Plan which may be accessed to obtain services that her physician determines are medically necessary for her.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for an exception from managed care.


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IT IS THEREFORE ORDERED that:

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

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: 

Date Mailed: 7.2.2012

***** 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.