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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-5230 MCE
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.*, 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 on [redacted]. [redacted] appeared on behalf of the Appellant who was present and testified. [redacted], Managed Care Exception specialist/MDCH, represented the Department.

ISSUE

Did the Department properly deny 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 [redacted]year-old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant resides in [redacted] County. (Appellant's Exhibit #1)

3. The Appellant is in that population required to enroll in a Medicaid Health Plan (MHP). (Department's Exhibit A, p. 2)

4. The Appellant is currently enrolled in the Midwest Health Plan effective [redacted]. (Department's Exhibit A, p. 2)

5. On [redacted], the Michigan Department of Community Health Enrollment Services Section received three (3) managed care exception

requests for review from doctors: [redacted], [PCP/internist], [redacted], [rheumatologist] and [redacted], [orthopedic surgeon]. (Department's Exhibit A, pp. 2, 9-13)

6. All of the reporting physicians (above) are participating members in managed care plans available to the Appellant – including Midwest. (*See* Department's Exhibit A – throughout)

7. The information submitted by the physicians did not describe the frequency and active treatment (monthly or greater) necessary to authorize exception from managed care. (Department's Exhibit A, pp. 2 and 22)

8. On [redacted], the Appellant's request for a managed care exception was denied - she was further advised to ask for a case manager to work with her in setting up her medical care needs. (Department's Exhibit A, pp. 2, 17 and 18)

9. On [redacted], the Appellant was sent a denial notification letter which included her managed care options and her further appeal rights. (Department's Exhibit A, pp. 2, 17 and 18)

10. On [redacted], the Appellant's request for an exception to Managed Care Enrollment was reviewed by MSA Chief Medical Officer, Dr. [redacted], M.D., who upheld the Department's decision. (Department's Exhibit A, pp. 2, 22)

11. The instant request for hearing was received from the Appellant on [redacted]. ((Appellant's Exhibit #1)

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.

The Medicaid Provider Manual (MPM), Beneficiary Eligibility §9.31, January 1, 2013, pp. 37-39, 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.

1 Identical to the version in place at the time of negative action and appeal.

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 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.

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The Appellant seeks medical exception owing to her serious medical condition.

Her representative argued that the Appellant would be better served in the FFS system owing to the dictates of various service providers and representatives of emergent care. She added that the Appellant is unable to obtain approval for certain non-formulary medications – believed to be necessary for the Appellant's full recovery.

The Department's witness, [redacted], testified that enrollment in managed care in no way represents a denial or limitation of a consumer's Medicaid – as the MHPs are contractually obligated to provide identical services as supplied in the FFS system.[2]

The MDCH Chief Medical Officer, Dr. [redacted], agreed with the Department reviewers and their conclusions that the Appellant's case did not present with the required frequency or active level of treatment necessary to further justify the requested exception. Indeed, review of the evidence shows that between the submitting physicians there was no frequency of treatment greater than quarterly. Her reported conditions, while serious, were considered manageable by her reporting physicians – who were enrolled in managed care available to the Appellant in [redacted] County. (*See* Department's Exhibit A at pages 2 and 22)

On review, the thrust of the Appellant's argument appears to be that certain medications and tests would be more widely available for her mother under FFS versus managed care. The mechanics of prior authorization were explained to the representative by the Department witness as was the contractual requirement which obligates the MHP to provide all medically necessary services to the Appellant.

I gave the testimony of Department witness [redacted] controlling weight. She clearly explained how the Appellant failed to qualify for medical exception and that appropriate treatment would be received within the MHP from the very physicians she desires to control her medical treatment – as of this writing. [She further explained the advantages of securing a Midwest-provided case manager to help negotiate the prior authorization process in the future].

The Appellant failed to preponderate her burden of proof.

2. In addition to transportation services which <u>are not covered</u> under FFS.

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 exception from managed care.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s\

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/2/2013

***** 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.