

**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:

██████████,

Appellant

_____ /

Docket No. 2013-35686 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's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held on ██████████. The Appellant was represented by ██████████. His witness was ██████████. ██████████ represented the Department. She had no witnesses.

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 ██████-year-old Medicaid beneficiary. (Appellant's Exhibit #1)
2. The Appellant resides in ██████████. (Appellant's Exhibit #1)
3. The Appellant is in that mandatory population required to enroll in a Medicaid Health Plan (MHP). (Department's Exhibit A, p. 2)
4. The Appellant is currently enrolled as a Fee-For-Service (FFS) Medicaid recipient and remains so enrolled during the pendency of this appeal. (Department's Exhibit A, p. 2)

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5. On [REDACTED], the Michigan Department of Community Health Enrollment Services Section received four (4) managed care exception requests for review from doctors; [REDACTED], M.D., an internist [2 copies]; [REDACTED], M.D. a neurologist; and an unidentified general surgeon. (Department's Exhibit A, pp. 8-11)
6. With the exception of the unidentified general surgeon, all of the reporting physicians (above) are participating members in managed care plans available to the Appellant. (See Department's Exhibit A – pp. 16-20)
7. The information submitted by these 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, 8 – 11)
8. On [REDACTED], the Appellant's request for a managed care exception was denied - he was further advised to ask for a case manager to work with him in setting up his medical care needs as he transitioned from FFS to managed care. (Department's Exhibit A, pp. 2, 13 and 14)
9. On [REDACTED], the Appellant was sent a denial notification letter which included his managed care options and his further appeal rights. (Department's Exhibit A, pp. 2, 13 and 14)
10. On [REDACTED], the Appellant's requests for Managed Care Exception were reviewed by MSA Chief Medical Officer, Dr. [REDACTED], M.D., who upheld the Department's decision to deny. (Department's Exhibit A, p. 15)
11. The instant request for hearing was received from the Appellant on [REDACTED] and scheduled for hearing on [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.

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 §9.3, April 1, 2013, 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.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

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 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 seeks medical exception owing to his multi-level, serious medical condition which requires significant coordination between medical suppliers of DME, many medications and a broad assortment of medical specialists. The Appellant's witness testified that it is a significant burden to coordinate these providers and feared that managed care would not be able or available to accommodate the Appellant.

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 under the FFS system.

The MDCH Chief Medical Officer, Dr. [REDACTED], agreed with the Department reviewer and her conclusion that the Appellant's case, [although serious], did not present with the required frequency or active level of treatment necessary to further justify the continued exception from managed care. Indeed, review of the evidence shows that between the submitting physicians there was no frequency of treatment greater than yearly. His conditions, while serious and complex were considered manageable through the managed care system. [See Department's Exhibit A, at pages 13 and 14)

On review, the thrust of the Appellant's argument appears to be that of a familiar comfort level with FFS versus the as yet untested services of managed care. The Appellant's representative was unaware of the breadth of available MHPs in [REDACTED] – but requested the ALJ go to decision on the Appellant's appeal.

The Appellant's representative has anxiety with the idea of participation in the managed care system. According to the Department witness all of his reporting specialists participate in managed care.¹

The Appellant failed to preponderate his burden of proof.

¹ [REDACTED] had documentation to prove such alliances at Depart. Ex. A, pp. 16-20

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

[REDACTED]
cc: [REDACTED]

Date Signed: 7/1/2013

Date Mailed: 7/1/2013

***** 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.