

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

P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 14-009722 MSB

██████████

██████████

Appellant

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on her own behalf. ██████████ Appeals Review Officer, represented the Department. ██████████, Medicaid Analyst with the Michigan Department of Community Health (MDCH, Department) Customer Service Division appeared as a witness for the Department.

ISSUE

Was the Appellant properly enrolled in the ██████████, a Medicaid Health Plan (MHP) effective ██████████, making her personally responsible for medical bills for two visits to the ██████████, a provider not enrolled with the Medicaid program?

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 a ██████-year old Medicaid beneficiary, born ██████████ (Bridges).
2. Appellant had private medical insurance with ██████████ until ██████████ (Exhibit A, pp. 6, 8, 9, 11 and testimony).
3. On ██████████, ██████████, and on ██████████, Appellant contacted the Department to have her private insurance coding ended in the Department's Medicaid processing system (CHAMPS). (Exhibit A, p. 6 and testimony).
4. On ██████████ and again on ██████████, Appellant incurred expenses for two visits to the ██████████, a

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- provider not enrolled with the Medicaid program totaling [REDACTED]. (Exhibit A, pp. 2, 6, 8-9, and testimony).
5. On [REDACTED], the Department was finally able to obtain verification of her private insurance ending on [REDACTED]. On [REDACTED], [REDACTED] determined that Appellant private insurance with [REDACTED] had terminated on [REDACTED]. (Exhibit A, pp. 2, 6, 8, 11 and testimony).
 6. The [REDACTED] Health Plan Process Schedule states that the MI Enrolls Enrollment Cut-Off Date for [REDACTED] was [REDACTED] for [REDACTED] it was [REDACTED] for [REDACTED] it was [REDACTED] and for [REDACTED] it was [REDACTED]. (Exhibit A, p. 14).
 7. The MDCH Contract with Medicaid Health Plans requires that enrollment with a contracting MHP will occur on the first day of the next available month following the eligibility determination and enrolment process. (Exhibit A, p. 16).
 8. The *Medicaid Provider Manual, General Information for Providers, Section 2 – Provider Enrollment*, p. 4, July 1, 2014, states that: “Providers (except managed care organizations) must have their enrollment approved through the on-line MDCH CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries.”
 9. On [REDACTED], [REDACTED] advised Appellant that she would have to be a private pay as they were not a Medicaid enrolled provider and that she was not enrolled in the [REDACTED]. (Testimony).
 10. On [REDACTED] sent the Appellant a bill for her [REDACTED] and [REDACTED] visits totaling [REDACTED]. (Exhibit A, p. 8).
 11. On [REDACTED], Appellant’s enrollment in the [REDACTED] a Medicaid Health Plan (MHP), became effective. (Exhibit A, pp. 2, 6, 12 and testimony).
 12. On [REDACTED], the Department received a Beneficiary Complaint form from the Appellant dated [REDACTED], asking that the Department pay the [REDACTED], [REDACTED] bill for her [REDACTED] and [REDACTED] visits totaling [REDACTED], because she believed she should have been enrolled in the MHP effective [REDACTED] and should have been covered by the [REDACTED] at the time of the two visits. (Exhibit A, pp. 8-9).

13. On [REDACTED], the Department sent the Appellant a letter stating because [REDACTED] was not an enrolled provider in the Medicaid program, Medicaid could not pay the provider and she was personally responsible for the [REDACTED] bill for her [REDACTED] and [REDACTED] visits. (Exhibit A, p. 10).
14. On [REDACTED], Michigan Administrative Hearing System (MAHS) received the Appellant's request for hearing. (Exhibit A, pp. 3-4).

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

Medicaid eligibility is a responsibility of the Department of Human Services through a contract with the Department of Community Health.

Policy covering enrollment in a Medicaid Health Plan is contained in the Bridges Administrative Manual, BAM 402, pp. 1-4 of 22. BAM 402 states in part:

Persons Excluded From Enrollment in a Health Plan

- PlusCare recipients.
- Persons limited to emergency MA coverage (ESO).
- Persons enrolled in the Children's Special Health Care Services (CSHCS) program only.
- Persons residing in an ICF/MR (intermediate care facility for the mentally retarded) or a state psychiatric hospital.
- Persons receiving long-term care (custodial care) in a licensed nursing facility.
- Persons receiving MI Choice waiver services for the elderly and disabled (LC code 22); see BEM 106.
- Persons receiving Private Duty Nursing Services.
- Persons with commercial HMO coverage, including Medicare HMO coverage.

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Note: Letters are mailed out each month to Medicaid recipients who have private HMO coverage. This letter informs recipients that they are being disenrolled from their Health Plan; see EXHIBIT IV for further information.

- PACE (Program for All-inclusive Care for the Elderly) recipients.
- Deductible beneficiaries.
- Children in child caring institutions.
- Refugee Assistance Program Medical Aid-only recipients.
- Repatriate Assistance Program Medical-only recipients.

Note: When a person(s) is excluded from health plan enrollment, other members of that person's family may enroll in a health plan.

If a beneficiary enrolled in a health plan enters a long-term care facility for custodial purposes, the health plan may initiate a request for disenrollment from the health plan; see BAM 120. The health plan may request disenrollment by calling:

Department of Community Health
Managed Care Plan Division
Quality Improvement and Program
(517) 241-8179

[Emphasis added].

The Department's witness established that because the termination of the Appellant's private insurance could not be verified until [REDACTED] the earliest date the Appellant's enrollment in the [REDACTED] a Medicaid Health Plan, could become effective was [REDACTED]. Despite the Appellant's earlier attempts to have the [REDACTED] termination date for her [REDACTED] private insurance entered into the CHAMPS system, the ending date was not processed until [REDACTED]. The [REDACTED] termination date was not verified by the Appellant's provider [REDACTED] until [REDACTED]. A provider that the Appellant herself acknowledged is not a Medicaid enrolled provider.

Appellant testified that she requested to be enrolled in the [REDACTED] MHP and assumed she was enrolled when she went to [REDACTED]. This is despite the fact that she never received any type of card or notification verifying her enrollment in the MHP. Appellant also acknowledged that she was advised before her [REDACTED] visit that she was not enrolled in the MHP and that the provider was not an enrolled Medicaid provider and did not accept straight Medicaid, but felt she had to continue going to her appointments or she would have been dropped by the provider.

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Appellant urges that her enrolment in the MHP should have been effective [REDACTED] since her private insurance ended [REDACTED]. However the MI Enrolls cut off for a [REDACTED] effective date was [REDACTED]. Since the Appellant had private insurance until the end of [REDACTED] according to BAM 402 she could not be enrolled in an MHP while she still had the private insurance. Accordingly, due to the MI Enrolls cut off dates, the earliest date she could have become enrolled in a MHP was [REDACTED]. Unfortunately, the CHAMPS system continued to show that the Appellant had private insurance until [REDACTED] which made [REDACTED] the first date her enrollment in a Medicaid Health Plan could become effective.

In any event, since the Appellant saw a provider who was not enrolled in Medicaid, when she was not yet enrolled in the [REDACTED] she is personally responsible for the [REDACTED] bill from [REDACTED] for her [REDACTED] and [REDACTED] visits totaling [REDACTED].

Based on the above findings of fact and conclusions of law, Appellant has failed to prove, by a preponderance of the evidence that she could have been enrolled in the [REDACTED], a Medicaid Health Plan (MHP) prior to the [REDACTED] effective date, or that the Department is responsible for the [REDACTED] bill from [REDACTED] for her [REDACTED] and [REDACTED] visits, totaling [REDACTED]. As such, the Department's actions must be upheld.

DECISION AND ORDER

The Appellant was properly enrolled in the [REDACTED], a Medicaid Health Plan (MHP) effective [REDACTED], making her personally responsible for medical bills for two visits to the [REDACTED], a provider not enrolled with the Medicaid program.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

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WDB/db

cc:



***** NOTICE *****

The Michigan Administrative Hearings 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 Hearings 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.