STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 24, 2016
MAHS Docket No.: 16-002410
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 Petitioner's request for a hearing.

After due notice, an in person hearing was held on [redacted], from Saginaw, Michigan. Petitioner [redacted] and Petitioner's daughter [redacted] appeared on behalf of the Petitioner; [redacted], (P[redacted]), Assistant General Counsel; [redacted], Member Grievance and Appeals Coordinator; [redacted], Manager Enrollment and [redacted], represented [redacted], the Medicaid Health Plan (MHP). [redacted], Hearings Facilitator represented the Michigan Department of Health and Human Services (Department).

This hearing is consolidated with Docket # 16-002419 [redacted] (Petitioner's spouse) as the issue is identical.

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for payment of medical bills?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. In [redacted], Petitioner came to the United States from [redacted].
2. Petitioner was granted a green card and given resident alien status.
3. Petitioner returned to [redacted] after six month and stayed there until [redacted].

4. Petitioner returned to the United States permanently in [redacted] and has resided in the United States continuously.

5. On [redacted], a telephone hearing addressing this same issue was held and presided over by Administrative Law Judge Colleen Lack, Docket #16-001923.

6. ALJ Lack's decision and order from Docket #16-001923 is herein incorporated in its entirety.

7. The Department's Computer System shows that Petitioner/Petitioner's spouse have been determined eligible for full Medicaid coverage since [redacted]013.

8. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating she and her husband were approved for full coverage Medicaid effective [redacted]. (Exhibit A, pp. 5-7)

9. The Department has received verification that Medicare was applied for and denied because Petitioner and her husband are not eligible for that program. (Exhibit A, pp. 1 and 9-10; Hearing Facilitator Testimony)

10. An error in the Department's computer system keeps flagging the Medicaid case that Petitioner and her husband are eligible for Medicare but not confirmed. (Exhibit A, pp. 1 and 12-31; Hearing Facilitator Testimony)

11. The Department has not issued any more recent case action notices regarding Medicaid for Petitioner or her husband. (Hearing Facilitator Testimony)

12. On [redacted], a hearing request was filed to resolve the Medicaid eligibility issue that is causing claims for Medicaid covered series to be denied. This has been going on for at least two years. (Exhibit A, pp. 2-4)

13. On [redacted], the Michigan Administrative Hearing System (MAHS) sent a letter requesting Petitioner's signature or other documentation to show the Authorized Hearing Representative was appointed.

14. On [redacted], the hearing request was re-submitted to MAHS with Petitioner's signature.

15. As of the [redacted], hearing date, the Department's computer system showed that Petitioner and her husband continue to be eligible for full Medicaid coverage, though there is another flag regarding Medicare. (Hearing Facilitator Testimony)

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Bridges Eligibility Manual (BEM) 257 addresses third party resource liability, including Medicare. A third-party resource is a person, entity or program that is, or might be, liable to pay all or part of a group member's medical expenses. An adult is required to cooperate with identifying third party resources unless they have good cause. Medicare Part B is not mandatory to pursue as a potential resource. However, when an individual refuses Medicare Part B, Medicaid will not pay for any Medicare Part B covered services they receive. BEM 257, May 1, 2015, pp. 1-3.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDHHS contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

Petitioners have received an approval notice for Medicaid eligibility from the Michigan Department of Health and Human Services. Petitioners have also received a letter from the Social Security Administration stating that they are not entitled to Social Security RSDI and are not eligible for Medicare. They cannot qualify for medical insurance because they are neither United States citizens nor aliens lawfully admitted for permanent residence and residing in the United States for at least five years in a row before filing for Medicare. Petitioners have provided the Department with proof of their lack of eligibility for Medicare.

The Department witness testified that a policy exception needs to be filed by the Department and a help desk ticket filed for BRIDGES so that the Department can consider whether or not Petitioners are eligible to receive payment for services provided in light of the fact that they established through the Social Security

Administration that they have not qualified for Medicare under any circumstances.

In the instant case, the Respondent MHP is not the appropriate Respondent under the circumstances. Eligibility is is determined by the Michigan Department of Health and Human Services. [redacted]' electronic files, received form the Department list Petitioners as being eligible under Managed Care Organization enrollment for beneficiaries with dual Medicare and full Medicaid eligibility. The Department may determine at any time that a member should be dis-enrolled and is not required to provide explanation for disenrollment. The [redacted] organization cannot determine eligibility for Medicaid or Medicare, nor establish a Medicaid Exception. The Department of Health and Human Services must make that determination.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the request for hearing as it pertains to [redacted] must be **DISMISSED** because the MHP is not the appropriate party to make a determination for eligibility for payment of a denied Medicaid claim. The MHP cannot establish a Medicaid exception.

IT IS, THEREFORE, ORDERED that:

> **The Michigan Department of Health and Human Services is ORDERED to initiate steps to determine whether or not Petitioners are entitled to a Medicaid policy exception and/or whether or not Petitioners are eligible for payment of Medicaid covered services under the circumstances.**

LL/[redacted]

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS [redacted]

DHHS -Dept Contact [redacted]

Community Health Rep [redacted]

Petitioner [redacted]

Authorized Hearing Rep. [redacted]