[redacted]

Date Mailed: 12/5/2022
MOAHR Docket No.: 22-004964
Agency No.: 0
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on November 30, 2022. Petitioner appeared and testified on her own behalf. Attorney Mark Kopson appeared on behalf of Aetna, the Respondent Medicaid Health Plan (MHP). Candice Dennis, Senior Grievance and Appeals Analyst; Laguire Burke, Supervisor, Grievance and Appeals; and Melissa Armstrong, Appeals Nurse, appeared as witnesses for Respondent MHP.

ISSUE

Did the MHP properly deny Petitioner's prior authorization request for an out-of-network provider?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary who was enrolled in Respondent MHP at all times relevant to this matter. (Exhibit A; Testimony)

2. On July 11, 2022, Petitioner's psychologist (Carry Ann Horn, PsyD of Pasadena, California) submitted a prior authorization request for treatment of bipolar disorder. (Exhibits A, pp 5-7; Testimony)

3. On July 20, 2022, Respondent sent Petitioner a Notice of Denial because the provider was not in Aetna's network. The Notice provided Petitioner the names of three in-network providers that were taking new patients and treated Petitioner's condition. (Exhibit A, pp 8-14; Testimony)

4. On July 21, 2022, Petitioner requested an internal appeal. (Exhibit A, p

16; Testimony)

5. On August 5, 2022, Respondent denied Petitioner's appeal, but enclosed contact information for three in-network providers who treat bi-polar disorder. (Exhibit A, pp 17-19; Testimony)

6. On October 28, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, pp 20-24)

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.

In 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 MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.)

> Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> *Medicaid Provider Manual*
> *Medicaid Health Plan Chapter*
> *July 1, 2022, p 1*
> *Emphasis added*

Pursuant to the above policy and its contract with the Department, the MHP has developed a prior authorization process subject to the limitations and restrictions described in the MHP's Medicaid agreement, the MPM, Medicaid bulletins, and other directives.

Respondent's witnesses testified that policy requires that all providers be in-network, unless treatment is unavailable in the network. (See Section 9.4, Non-Participating Providers in the Aetna Better Health of Michigan 2022, Healthy Michigan Member Handbook). Respondent's witnesses indicated that in-network providers must go through a rigorous credentialing process to ensure that all beneficiaries receive safe and proper treatment. Respondent's witnesses testified that they provided Petitioner with the names of three providers in the Notice of Denial who were all accepting new patients and treated Petitioner's condition, bi-polar disorder. Respondent's witnesses indicated that when Petitioner pointed out that the Notice did not include contact information for the providers, Respondent provided that information.

Petitioner testified that when she wrote the initial appeal letter, she did not have any contact information for the recommended providers. Petitioner indicated that she wants to see a provider that shares her values and core beliefs and the provider in California met those criteria. Petitioner also testified that the California provider specializes in the type of treatment she needs, and she has been unable to find someone locally who specializes in her needs and shares her values and core beliefs. Petitioner indicated that she knows Respondent can pay out-of-network providers and is requesting an exception to policy in this instance. Petitioner testified that Respondent should take a more humane stance when dealing with patients with mental health issues. Petitioner pointed out that she is not asking Respondent to pay more for the California provider.

Given the above policy and evidence, Petitioner has failed to prove by a preponderance of the evidence that the MHP erred in denying the prior authorization request. Policy clear indicates that Respondent is authorized to develop prior authorization requirements and policies that are consistent with Medicaid policy. Here, the policy requiring in-network providers is consistent with Medicaid policy and the undersigned

has no authority to ignore clear policy. While the undersigned is sympathetic to Petitioner's position, he has no authority to grant Petitioner any relief in this matter.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Petitioner's request for prior authorization to see an out-of-network provider.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

RM/sj

Robert J. Meade
Administrative Law Judge

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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

Via Electronic Mail:

DHHS Department Contact
Managed Care Plan Division
CCC, 7th Floor
Lansing, MI 48919
MDHHS-MCPD@michigan.gov

Community Health Representative
Aetna Better Health of Michigan
Grievances and Appeals - Aetna Better Health of MI
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