STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 11F-07663

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 19 Martin
UNIT: HMO

FILED
Dec 14 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 18, 2011, at 9:18 a.m.

APPEARANCES

For the petitioner: [redacted], petitioner

For the respondent: [redacted], management analyst, Area 9 Medicaid, Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing a denial of disenrollment from the HMO Health Ease to enroll in Medipass based on her contention that she is not able to get a specialist to continue her treatments because her current specialist will no longer treat her as he has not been paid.

PRELIMINARY STATEMENT

The petitioner is seeking disenrollment from [redacted] (health maintenance organization), outside of the general enrollment period, to Medipass to continue treatment with [redacted], an oncologist. [redacted] entered into a Single Case Agreement with [redacted] as a non-participating network provider to allow him to treat petitioner's medical issue; a rare form of lymphoma.

[redacted], RN, an advocate for petitioner, and [redacted], RN, [redacted], gave testimony on petitioner's behalf.

Petitioner introduced one exhibit which was accepted into evidence and marked as the Petitioner's Exhibit 1.

Respondent's witnesses from [redacted] included [redacted], director of regulatory affairs, and [redacted] regulatory affairs specialist. Present from the Agency for Health Care Administration (ACHA) were [redacted], medical health care program analyst, and [redacted], medical review monitor.

Respondent introduced a composite exhibit consisting of 150 pages, which was accepted into evidence and marked as the Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing, and on the entire record of the proceeding, the following Findings of Fact are made:

1. Petitioner is a 26 year old Medicaid beneficiary enrolled with [redacted] HMO since August 1, 2010.

2. On September 7, 2011, she was diagnosed with stage 3b cervical cancer lymphoma, a rare form of lymphoma.

3. On September 8, 2011, she filed a grievance with [redacted] because she was having difficulty locating a network specialty provider (oncologist) in her area.

4. Petitioner explains that on September 11, 2011, she saw a radiation oncologist in [redacted] FL, who told her she needed to see a medical oncologist to start chemotherapy. She was referred to [redacted], a medical oncologist and Medicaid provider.

5. On September 15, 2011, petitioner's primary care physician requested that she be able to see [redacted], a non-participating (out of network) provider, and that she receive authorization for a consultation at [redacted].

6. On September 19, 2011, a Single Case Agreement was completed with [redacted] to provide oncology services to the petitioner.

7. On September 20, 2011, authorizations were approved for the consult at [redacted] and two doctors.

8. In September and October 2011, authorizations were approved for a bone marrow biopsy, a doppler echo heart exam, and chemotherapy.

9. On October 6, 2011, the grievance was closed with the following decision. Petitioner was approved to see [redacted] as an out of network provider effective September 15, 2011 through November 15, 2011 (page 10/150 Respondent's Composite Exhibit 1). Petitioner was also informed that her case was forwarded to the case management department for anticipation of her future needs. She has been instructed to use her case manager for her medical needs. She was advised that Medicaid offers transportation if that was a barrier to getting to the doctor. [redacted] was unable to disenroll her from its plan; the local Medicaid office had to make that decision.

10. For petitioner, open enrollment is in May 2012. In order for petitioner to switch from HMO to Medipass before the open enrollment period, she must have a good cause reason. Originally, she was denied good cause because she had not completed the grievance process and because she had not utilized network doctors available to her. Petitioner did complete the grievance process. She was then denied because there were doctors available to her in the area, and because a non participating provider was secured for her care at her primary doctor's request. [redacted] of the AHCA, notes that if petitioner asked now to disenroll from her HMO to switch to Medipass, she would still be denied because there are other doctors available to her. [redacted] with [redacted], listed at least 10 participating oncologists within driving distance from petitioner's home.

11. Petitioner asserts that she does have a case manager at [redacted], but she has to find doctors on her own. She further asserts that the doctors on the list she received from [redacted] are no longer providers; such as the ones at [redacted]. She has a doctor [redacted] that would treat her and has been treating her, and according to her, will continue to treat her only if she switches to Medipass. She started her treatments on October 18, 2011, and needs 6-8 cycles every three weeks. Petitioner's advocate is concerned about the burden that would be placed on the petitioner if she has to wait for a new provider, who may change her protocol and/or delay her treatment. She believes it is in the best interest of the petitioner to disenroll her and allow the switch to Medipass so she can continue treatment with [redacted].

12. Respondent was not aware of any payment issues with [redacted] for his services rendered. [redacted] stated that [redacted] will do what it takes to get petitioner's services and has not denied her any service or access to a doctor or treatment. In fact,

he notes that [redacted] has fulfilled its contractual obligation by securing a single case agreement with [redacted], and if treatment cannot be found for petitioner; he would help with a smooth transition if petitioner was disenrolled at a later time.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to §120.80 Fla. Stat. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

14. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

16. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.

18. Fla. Stat. 409.912 states, in relevant parts:

> Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.

> (3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

19. The current Florida Medicaid Provider General Handbook is incorporated by reference in the Medicaid Services Rules as found in Fla. Admin. Code chapter 59G-4. Page 1-28 of the above Handbook states, in part:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

20. The Florida Medicaid Summary of Services lists the services each HMO must provide. These services include a network of doctors, hospitals, clinics, and drugstores.

21. Fl. Stat. 409.969 Enrollment; disenrollment.— states:

> (1) ENROLLMENT.—All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this part. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans.
>
> (2) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. For purposes of this section, the term “good cause” includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan’s grievance process before the agency’s determination of good cause, except in cases in which immediate risk of permanent damage to the recipient’s health is alleged.
> (a) The managed care plan internal grievance process, when used, must be completed in time to permit the recipient to disenroll by the first day of

> the second month after the month the disenrollment request was made. If the result of the grievance process is approval of an enrollee's request to disenroll, the agency is not required to make a determination in the case.
> (b) The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.
> (c) Medicaid recipients enrolled in a managed care plan after the 90-day period shall remain in the plan for the remainder of the 12-month period. After 12 months, the recipient may select another plan. However, nothing shall prevent a Medicaid recipient from changing providers within the plan during that period.

22. The above cited passage explains enrollment and disenrollment and the steps involved in each. Petitioner enrolled in [redacted] in August 2010. She is currently seeking disenrollment. As it is beyond the 90 day period in which to voluntarily disenroll, in order to do so, petitioner must have good cause reason and the Agency must make a decision as to whether or not to disenroll outside of the normal enrollment period. In this instant appeal, petitioner seeks disenrollment from [redacted] to go to a doctor that accepts Medipass.

23. Fla. Admin. Code 59G-8.600 Good Cause for Disenrollment from Health Plans states:

> (1) Recipients subject to the 12-month enrollment period may request disenrollment from the health plan for cause at any time during their no-change period. The no change period is defined as the period of time during which a recipient cannot change plans without a good cause reason in accordance with 42 CFR 438.56(c). Recipients making such requests must submit the request to the call center representative for a determination.
> (2) Good Cause Reasons. The following reasons constitute good cause for disenrollment from the health plan:

(a) The recipient moves out of the county, or the recipient's address is incorrect and the recipient does not live in a county, where the health plan is authorized to provide services.
(b) The recipient is excluded from enrollment.
(c) A marketing violation occurred with the individual recipient that is substantiated by the Agency for Health Care Administration, Bureau of Managed Health Care. The recipient must submit the allegation in writing to the Bureau of Managed Care, 2727 Mahan Drive, M.S. 26, Tallahassee, FL 32308.
(d) The recipient is prevented from participating in the development of his treatment plan.
(e) The recipient has an active relationship with a health care provider who is not on the health plan's network, but is in the network of another health plan; or the health care provider with whom the recipient has an active relationship is no longer with the health plan.
(f) The recipient is ineligible for enrollment in the health plan.
(g) The health plan no longer participates in the county in which the recipient resides.
(h) The recipient needs related services to be performed concurrently, but not all related services are available within the health plan network; or the recipient's primary care provider (PCP) has determined that receiving the services separately would subject the recipient to unnecessary risk.
(i) The health plan does not, because of moral or religious objections, cover the service the recipient seeks.
(j) Poor quality of care.
(k) Lack of access to services covered under the contract, including lack of access to medically-necessary specialty services.
(l) The health plan makes inordinate or inappropriate changes of the recipient's primary care provider (PCP).
(m) An unreasonable delay or denial of service.
(n) Service access impairments due to significant changes in the geographic location of services.
(o) There is a lack of access to health plan providers experienced in dealing with the recipient's health care needs.
(p) Fraudulent enrollment.
(q) The recipient, although otherwise locked in, requests enrollment in a specialty plan and meets the eligibility requirements for the specialty plan.
(r) The recipient received a notice from their plan of a reduction in required benefits at the end of the plan's annual contract year (for the next year).

24. The above cited passage also directs AHCA to make a determination if good cause exits. Good cause was denied as the petitioner was receiving treatment from a nonparticipating doctor that was approved to treat petitioner and there were other

physicians in the network within the area. The respondent argues that petitioner's request to switch to Medipass is her personal preference; not one based on lack of area providers.

25. Testimony revealed that the same doctor that petitioner wants to go to that accepts Medipass is the same doctor [redacted] secured a Single Case Agreement with to provide her current care. She has been receiving care from this doctor. Petitioner made statements that [redacted] is not getting paid for his services and that he no longer will provide for petitioner's care, however, she provided no corroborating evidence to substantiate these claims. This testimony is also in contradiction to testimony provided by the respondent who was not aware there was a problem with payment.

26. The reasons for good cause include poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, among others. The undersigned has considered the testimony presented and the above cited rules and concludes that the petitioner has not met her burden of proof in this matter to show that she should be disenrolled from [redacted] HMO and have the opportunity to switch to Medipass. Respondent has complied with petitioner's request to receive services from [redacted]. His services were secured through a Single Case Agreement. There was no evidence presented to show there are no oncology providers within the allotted driving distance from her home from whom she could seek treatment and at least 10 names were given from respondent's current list. The standard of proof in a fair hearing is by a preponderance of evidence and the hearing officer concludes that the petitioner has not met her burden of proof. Therefore, petitioner has not demonstrated good cause to

disenroll and her request to disenroll from [redacted] to seek treatment from a physician that accepts Medipass is not consistent with the rules or intent of the Program when the same physician has been granted approval to treat her now on the HMO she is enrolled in.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this _____ day of _____, 2011,

in Tallahassee, Florida.

_____

Margaret Poplin
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