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

[redacted]

APPEAL NO. 14F-09483

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 St. Johns
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 16, 2015 at 1:17p.m.

APPEARANCES

For the Petitioner: The petitioner represented herself

For the Respondent: Jackie Allison, human service program specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

The petitioner wishes to disenroll from Sunshine health maintenance organization and enroll with another health plan.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (the Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with numerous health plans to provide medical services to its program participants.

By notice dated September 25, 2014, the Agency informed the petitioner that her request to change Medicaid health plans was denied. The letter reads in pertinent part: "Your request does not meet state approved Good Cause reason to leave your MMA [Managed Medical Assistance] plan."

On November 5, 2014, the petitioner requested a hearing to challenge the Agency's decision.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

There were no additional witnesses for the respondent. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business of January 21, 2015 for the submission of additional evidence. Evidence was received from the Agency and admitted as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. In 2014, the Agency began transitioning Medicaid recipients to Managed Care Plans. Medicaid rules require that, with a few exceptions, program participants receive their health care services through a Managed Care Plan (MCP) and primary care provider (PCP). Enrollees are allowed to change MCPs within the first 90 days of

enrollment and during open enrollment periods; otherwise enrollees are locked into their MCP, unless they meet a good cause exception. The Agency's definition of 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.

2. The petitioner receives Supplemental Security Income (SSI). As a SSI recipient, the petitioner also receives full coverage Medicaid. The petitioner's MCP is Sunshine State (Sunshine). The petitioner's PCP is Dr. [redacted]

3. The petitioner suffers from severe asthma that frequently requires immediate medical intervention. The petitioner's PCP does not accept walk-in-appointments. During a recent asthmatic episode, the petitioner's PCP could not see her for two weeks.

4. The petitioner is not satisfied with the quality of care she has received through Sunshine. The petitioner argues that her health care needs cannot be met by Sunshine. In addition, to the issue with her PCP, it has been difficult for her to find local medical providers who accept Sunshine. Further still, the dental services available through Sunshine are fewer than those offered by other area MCPs. The petitioner would like to change to Staywell Health Plan (Staywell).

5. The Agency was not aware of the petitioner's asthma or two week wait for an appointment with her PCP prior to the hearing. The Agency requested an opportunity to explore if the petitioner met a good cause reason to change MCPs. The hearing record was held open for five days for the Agency to complete its review.

6. The Agency determined that the petitioner did not have a good cause reason to change MCPs during a lock-in period because she did not file a grievance with her MCP prior to requesting a hearing. The Agency suggested that the petitioner, through her current plan, locate a PCP that "would allow walk-in appointments." PCP changes can be made anytime.

CONCLUSIONS OF LAW

7. By agreement between the AHCA 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.

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

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

11. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

12. The Florida Medicaid program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid program is administered by the Agency.

13. Fla. Stat. § 409.965 addresses mandatory enrollment in Medicaid Managed Care:

> All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver. The following Medicaid recipients are exempt from participation in the statewide managed care program:
>
> (1) Women who are eligible only for family planning services.
>
> (2) Women who are eligible only for breast and cervical cancer services.
>
> (3) Persons who are eligible for emergency Medicaid for aliens.

14. The cited authority explains that unless a Medicaid participant meets one of the exceptions cited above, he or she must participate in the statewide manage care program. The petitioner does not meet an exception. She must participate in the managed care program.

15. Fla. Stat. § 409.969(2) addresses 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.

16. The cited authority allows plan participants to disenroll after the initial 90 day period for good cause. Good cause includes unreasonable delay or denial of service. The authority explains that a recipient is not required to use the plan's grievance process when he or she alleges immediate risk of permanent health damage.

17. The evidence proves that the petitioner suffers from severe asthma that frequently requires immediate medical attention. During a recent asthmatic episode, the

petitioner had to wait two weeks for an appointment, placing her at risk of permanent health damage.

18. The undersigned concludes that the petitioner has good cause reason to change HMOs.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The petitioner is to be allowed to disenroll from Sunshine and choose another participating regional HMO.

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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 3rd day of February, 2015, in Tallahassee, Florida.

Leslie Green

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Copies Furnished To: [redacted] Petitioner
Lisa Broward, Area 4, AHCA Field Office Manager