FILED
MAY 26 2015
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
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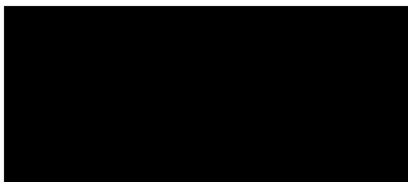


APPEAL NO. 15F-01144

PETITIONER,

Vs.

CASE NO.

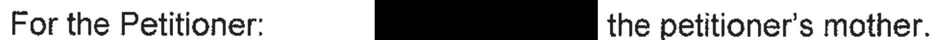
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 28, 2015, at 9:00 a.m.

APPEARANCES



For the Petitioner: the petitioner's mother.

For the Respondent: Lisa Sanchez, Senior Program Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency's action in denying petitioner's request for exemption from the Statewide Medicaid Managed Care Program was correct. The petitioner is requesting to receive fee-for-service, straight Medicaid, as opposed to

enrollment in the Medicaid MMA (Managed Medical Assistance) plan with Prestige Health Choice.

PRELIMINARY STATEMENT

Present as a witness for the respondent was Kimberly Lewis, Director of Grievance and Appeals, with Prestige Health Choice.

The respondent submitted into evidence Respondent Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner began receiving SSI-Related Medicaid due to an accident that caused him brain damage. The petitioner has been enrolled in the MMA plan with Prestige Health Choice since January 2015. Previously, he was enrolled in fee-for-service or straight Medicaid.

2. In January 2015, the petitioner requested an exemption from enrollment in the MMA Plan through the Agency (AHCA). On January 15, 2015, the Agency denied the petitioner's request and provided a Notice stating:

> Based on our records, you will have to enroll in an MMA Plan in order to receive your Medicaid services.

3. The respondent's representative explained the petitioner does not meet an exemption that allows him to receive fee-for-service Medicaid, according to sections 409.965, 409.971 and 409.972, Florida Statutes.

4. The petitioner's representative argued the petitioner's previous Medicaid doctors are not providers with Prestige. She argued the fee-for-service Medicaid doctors provide excellent care for the petitioner, and the doctors who are providers with Prestige do not seem to care about the petitioner. She argued her only interest is that the petitioner receive the best health care he can receive.

5. The respondent's witness indicated the petitioner has the opportunity to enroll in case management, where the Prestige staff can assist the petitioner with any Medicaid type services available. In addition, she explained case management could assist in communicating with the petitioner's previous doctors to explain how they may become Prestige providers.

6. The petitioner's representative agreed to the above, but would still rather have the petitioner receive straight Medicaid coverage.

PRINCIPLES OF LAW AND ANALYSIS

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

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

10. Fla. Stat. § 409.965 addresses mandatory enrollment in the Statewide Medicaid Managed Care Program and states:

> 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.

11. Fla. Stat. § 409.971 addresses the managed medical assistance program and states:

> The agency shall make payments for primary and acute medical assistance and related services using a managed care model. By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2014.

12. Fla. Stat. § 409.972 addresses mandatory and voluntary enrollment in the managed medical assistance program and states:

> (1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:
> (a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
> (b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).
> (c) Persons eligible for refugee assistance.
> (d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
(f) Medicaid recipients residing in a group home facility licensed under chapter 393.
(g) Children receiving services in a prescribed pediatric extended care center.
(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.
(3) The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

13. As shown in the Findings of Fact, the Agency denied the petitioner request for exemption from the Statewide Medicaid Managed Care Program.

14. For the case at hand, there was no evidence presented to show the petitioner meets criteria for exemption from mandatory participation in the statewide managed care program. The above-cited authorities do not provide an exemption for the petitioner's preference of former Medicaid providers.

15. After considering the evidence and all of the authorities set forth above, the hearing officer concludes the petitioner has not met his burden of proof, and the Agency's decision to deny the request for exemption from the Statewide Medicaid Managed Care Program was correct.

DECISION

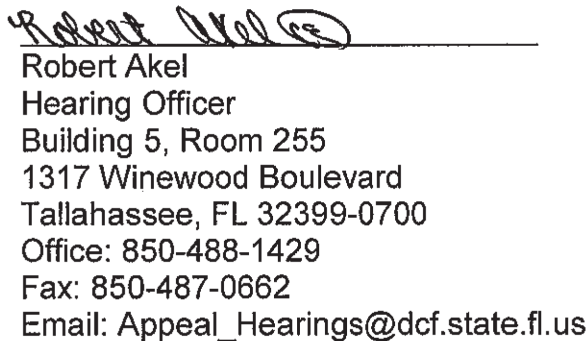
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Agency action affirmed.

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

DONE and ORDERED this 26 day of May, 2015,

in Tallahassee, Florida.



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