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

[redacted]

APPEAL NO. 15F-03212

PETITIONER,

Vs.

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 May 11, 2015 at 10:35am.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Doretha Rouse, Registered Nurse Specialist,

STATEMENT OF ISSUE

Petitioner is appealing the Agency's decision to deny her request to change Managed Care Plans. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (the Agency or AHCA or respondent) administers the Florida Medicaid Program.

Present as a witness for the Agency was Esther Pierre-Louis, Supervisor of Grievance and Appeals with Prestige Health Choice. The Agency provided information prior to hearing which was entered as Respondent Exhibit 1.

FINDINGS OF FACT

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

1. Prior to the appeal, the petitioner was enrolled with United Healthcare to provide Medicaid covered services.

2. The Agency mailed the petitioner a letter dated October 2, 2014 regarding managed care open enrollment. The letter advised that she had a right to change plans within 90 days. After the 90 days, no further changes could be made except for good cause until the next year during open enrollment.

3. The Agency makes good cause determinations when a recipient calls and makes the request to change plans. The Agency does not mail a written notice; it informs the recipient during the phone call of its good cause determination.

4. The petitioner was enrolled with Prestige Health effective November 1, 2014 as she failed to choose a plan during the time period allowed.

5. The petitioner believed she received the letter "outdated" and postmarked after the date on the letter. She believed she would remain in her plan unless she requested to change but before she could choose, it was chosen for her. Petitioner admits "I dropped the ball at switching my provider."

6. The petitioner was in the hospital mid March 2015. She was told she had stage one liver disease as well as a urinary tract infection. The specific disease was not identified at discharge.

7. The hospital referred her to an internal medicine physician for follow up. However, she was prevented from seeing this physician as he did not accept Prestige. Petitioner could have been seen by this physician shortly after discharge from the hospital.

8. The participating physicians in the Prestige network could not see her until June 2015. She is currently scheduled to see her newly assigned primary care physician on June 16, 2015.

9. The petitioner filed a grievance with Prestige on March 19, 2015 requesting disenrollment from the plan so that she could return to United Healthcare and be seen timely.

10. Prestige contacted the physician petitioner wanted to see and he would not join the Prestige network. Prestige notified the petitioner by letter dated March 23, 2015 that she could choose another physician within the plan.

11. The petitioner contacted the Agency on March 27, 2015 requesting assistance changing her managed care plan. The petitioner spoke with Ms. Rouse who verbally advised petitioner she did not meet the good cause exceptions to change plans. She was verbally advised she had a right to a Medicaid Fair Hearing. The Agency did not issue a written notice.

12. Ms. Rouse indicated she had no evidence to suggest petitioner's condition was life threatening to grant a good cause exception under this criterion.

13. The petitioner expressed concern about the urgency of the matter as she argues this is a life-threatening condition. The time which has already lapsed makes the issue practically moot as it is now almost June when she has an appointment and upcoming open enrollment. However, petitioner still seeks the reversal of the denial of her disenrollment request.

14. The petitioner's gynecologist does not accept Prestige. She saw this physician one time approximately one year ago.

15. The petitioner's United Healthcare primary care physician is no longer in practice.

PRINCIPLES OF LAW AND ANALYSIS

16. By agreement between the Agency for Health Care Administration (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.

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

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

19. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code § 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.).

20. Fla. Stat. 409.963 "Single state agency" states in part, "The agency is designated as the single state agency authorized to manage, operate, and make

payments for medical assistance and related services under Title XIX of the Social Security Act."

21. The above statute indicates that AHCA is the single state agency authorized to manage and operate payment for services under Medicaid.

22. Fla. Stat. 409.969 "Enrollment; disenrollment" states in part:

> (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.

23. The above statute sets forth the disenrollment procedures for Medicaid recipients and states that voluntary disenrollment can take place by the recipient within 90 days to select another plan. After that, changes can only be made for good cause. The statute lists some examples of good cause as "poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment." The statute places good cause determination on AHCA and also states "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." The language anticipates an urgency of the process when there is immediate risk of permanent damage to the recipient's health. Petitioner's situation is unknown at this point as to an immediate risk of permanent damage. There was no evidence to show she either was or was not in immediate risk of permanent damage.

24. Fla. Admin. Code § 59G-8.600 "Good Cause for Disenrollment from Health Plans" states in relevant part:

> (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. (emphasis added)
> (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.** (emphasis added)
> (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). (emphasis added)

25. According to the above authority, good cause for disenrollment in a health plan is defined as an unreasonable delay of service as well as when a recipient has an active relationship with a provider in another health plan. The undersigned notes that "unreasonable delay" and "active relationship" are not defined relative to this rule. The agency did not provide a definition of these terms.

26. Petitioner was told upon discharge from the hospital in March 2015 that she had

some type of liver disease and would need follow up with an internist. Petitioner admits she dropped the ball in switching her plan. Petitioner first attempted to use the plan she was assigned, however there were no available appointments until three months out. Petitioner also next tried the current plan's grievance process and was denied. Petitioner then tried to show good cause with the Agency so that she could return to her previous plan and was denied good cause. Petitioner next filed for this Medicaid Fair Hearing.

27. The undersigned finds petitioner's argument persuasive in that she has been prevented from a timely follow up appointment with an internist (shortly after discharge) due to the denial of her request to return to her previous plan to be evaluated for the liver disease. This is one of the good cause reasons identified in the state's rules. The undersigned concludes that petitioner met the good cause exemption of "unreasonable delay" (three months after discharge) and in addition, petitioner had a previous relationship with a gynecologist (even though she was only seen once). By being allowed to return to her gynecologist petitioner can have a continuity of care which cannot be achieved by changing to a new gynecologist and starting over.

28. The time delay in this matter is unfortunate; however, petitioner is to be allowed to return to United Healthcare as soon as possible so that she may seek appropriate treatment with no further delay.

DECISION

Based upon the foregoing Findings of Fact and Principles of Law and Analysis, the appeal is granted. The Agency is to grant petitioner's good cause request and allow her to return to her previous plan in an expedited manner.

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 14 day of May, 2015, in Tallahassee, Florida.

Melissa Roedel
Hearing Officer
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Copies Furnished To [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office