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

[redacted]

APPEAL NO. 12F-01458

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: HMO

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 16, 2012 at 9:03 a.m. by telephone.

APPEARANCES

For Petitioner: [redacted]
Petitioner's Father

For Respondent: [redacted]
Agency for Health Care Administration

ISSUE

Whether petitioner has established good cause to change his Medicaid Managed Care plan prior to open-enrollment.

PRELIMINARY STATEMENT

At the hearing, respondent was represented by [redacted] a Medical/Health Care Program Analyst with the Agency for Health Care Administration (AHCA). Also present for respondent was [redacted], a Medical/Health Care Program

Analyst, and [redacted] Manager of Appeals and Grievance with [redacted] Respondent presented one composite exhibit which was accepted into evidence and marked as respondent's exhibit "1." Petitioner was represented by his father, [redacted] petitioner presented no exhibits. Also, present at the hearing as an observer was AHCA employee [redacted]

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. Petitioner is a minor child currently enrolled in the Medicaid Managed Care health plan, [redacted] Respondent has contracted with [redacted] to provide health benefits.

2. Petitioner has been enrolled with [redacted] beyond the period for which he can voluntarily disenroll.; he seeks disenrollment from the plan and immediate enrollment in United, another Medicaid Managed Care plan.

3. Petitioner's request for disenrollment was made in February. On February 14, 2012, [redacted] sent petitioner a letter acknowledging receipt of a grievance he filed. The letter identifies the grievance as being related to petitioner's difficulty in finding a pediatric urologist specialist within the plan. Attached to the letter was a list of seven pediatric urologist specialists. The specialists were located between 29.2 and 49.7 miles from petitioner's residence, with a travel time of less than sixty minutes each way.

4. [redacted] contract with respondent provides, "[a]ll participating specialists and ancillary providers must be within an average of sixty (60) minutes' travel time from an enrollee's residence." *See* Respondent's Exhibit 1.

5. Petitioner seeks the services of a pediatric urologist specialist. Petitioner was seen by an urologist in an emergency room; however, he has not been and is not currently under the care of a pediatric urologist.

6. Petitioner is dissatisfied with the amount of travel time required to see an [redacted] pediatric urologist specialist.

7. On February 23, 2012, petitioner filed a request for fair hearing with the Office of Appeal Hearings, stating he wants to change Medicaid Managed Care plans.

8. Petitioner argued United has pediatric urologist specialists available locally with less travel time involved. Petitioner also argued he was required to submit additional documentation prior to seeing a separate physician, which was unreasonable. Petitioner contends the lack of availability and request to submit additional documentation establish good cause for his immediate disenrollment.

9. Respondent argued Medicaid's contract provides that services of a specialist must be within sixty-minutes of travel time of petitioner's residence. Respondent contended specialists are available as permitted by the contract. Respondent concluded and good cause has not been shown.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 120.80. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

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

14. Pursuant to Fla. Admin. Code R. 65-2.060(1) the burden of proof was assigned to the petitioner.

15. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by 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.).

16. Florida Statute § 409.912 provides that respondent "… shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care." In addition, the Statute provides respondent may contract with health maintenance organizations, which respondent has done with Amerigroup.

17. Florida Statute § 409.969(2) provides in pertinent part:

> (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. …

18. Florida Administrative Code Rule 59G-8.600 sets forth the reasons for good cause disenrollment from a health plan. Upon review of the Rule, petitioner's allegations do not satisfy the requirements. Amerigroup's contract, as permitted by Fla. Stat. § 409.912, requires the plan to have specialists within a sixty minute travel time from petitioner's residence; respondent submitted evidence establishing that such specialists are available. Although the travel time provided by the contract may be an inconvenience, Amerigroup has demonstrated petitioner has access to specialists in compliance with the contract.

19. Petitioner further argued Amerigroup required that he submit additional documentation before authorizing him to see another physician. Florida's statutes allow Medicaid Managed Care plans to implement a prior service authorization process whereby the plan may request additional documentation prior to giving authorization. Petitioner's argument does not demonstrate that he suffered a substantial and unreasonable delay in seeing an [redacted] physician.

20. Petitioner's allegations in support of his disenrollment from [redacted] do not meet the good cause requirements of Fla. Admin. Code R. 59G-8.600. After considering the evidence and relevant laws set forth above, petitioner has not met his burden of proof that respondent's action was in error.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is hereby DENIED and 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 _____, 2012,

in Tallahassee, Florida.

_____
Michael Sauvé
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Copies Furnished To: [redacted] Petitioner
[redacted], Area 6 Medicaid Field Manager
[redacted] AHCA