



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED

Apr 05, 2023, 10:10 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0127

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 9, 2023, at 9:02 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Suzanne Chillari
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that the Respondent's denial of Petitioner's For Cause disenrollment request was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative and [REDACTED]

[REDACTED] (" [REDACTED] "), appeared on behalf of the Petitioner.

Suzanne Chillari (“Ms. Chillari”), Medical/Health Care Program Analyst with the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent.

Prior to the hearing, Petitioner send to the Office of Fair Hearings and Respondent a one (1)-page letter. This letter appears in the Office of Fair Hearings’ document management system as file title “23-FH0127 Dar & Supporting Documents.pdf”. Absent an objection from Respondent, the undersigned admitted the one (1)-page letter into evidence as Petitioner’s Exhibit 1 (“PE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a twenty (20)-page evidence packet. This twenty (20)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “Agency SOM_Evidence Packet 23-FH0127.pdf”. Absent an objection from Petitioner, the undersigned admitted the twenty (20)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana Healthy Horizons, Inc. (“Humana”). See page 13 and 17 of RCE 1. Humana is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. On [REDACTED] Petitioner’s Authorized Representative filed a grievance with Humana. *Id.* at 2. On [REDACTED], Humana issued to Petitioner a Grievance Acknowledgement Letter. *Id.* at 13.

3. On [REDACTED], Humana issued to Petitioner a Grievance Resolution Letter. *Id.* at 16. The Grievance Resolution Letter reads as follows in pertinent part:

On [REDACTED], and [REDACTED], Humana Healthy Horizons attempted to contact you to obtain more information regarding your disenrollment request. Unfortunately, we were unable to reach you.

On [REDACTED], our records show you spoke to the Nurse Advice Line regarding your disenrollment request. During this conversation, you said that you found an out-of-network neurologist that would treat your [REDACTED]. You said that you would like for your [REDACTED] to see this provider and declined additional assistance.

...

Page 17 of RCE 1.

4. On [REDACTED], Petitioner's Authorized Representative requested a For Cause plan change from Humana to Children's Medical Services ("CMS"). *Id.* at 1. Petitioner's Authorized Representative requested the change due to the need for related services to be performed concurrently. *Id.*

5. On [REDACTED], the Agency reviewed and denied the request for a For Cause plan change because the action taken by Humana in the Grievance Resolution Letter was deemed appropriate. *Id.* at 2.

6. On [REDACTED], a letter of Denial of For Cause plan change was issued to Petitioner's Authorized Representative. *Id.* at 3. The letter reads as follows in pertinent part:

The reason given for the requested For Cause plan change, outside of your Open Enrollment period, was the enrollee needs related services to be performed concurrently, but not all related services are available within the managed care plan's network, and the enrollee's primary care provider (PCP) has determined that receiving the services separately would subject the enrollee to unnecessary risk. The Agency has considered your request and denied it as it does not meet the requirements for a For Cause plan change as outlined in Rule 59G-8.600. The request was denied because the Grievance process is complete and the action taken by the plan is deemed appropriate – as outlined in your Plan's Grievance resolution letter.

...

Page 3 of RCE 1.

7. On January 23, 2023, Petitioner's Authorized Representative requested a Fair Hearing regarding the denial of a For Cause plan change. *Id.* at 2. On February 9, 2023, the undersigned

issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for March 9, 2023, at 9:00 a.m. EST.

8. [REDACTED] is the [REDACTED] and Authorized Representative of Petitioner. [REDACTED]

testified to the following at the Fair Hearing:

- a. [REDACTED] stated [REDACTED] tried but was unable to disenroll from Humana during Open Enrollment due to an active grievance that had not yet received a resolution.
- b. Petitioner lives in a rural area and there are very few providers nearby. The out of network provider Petitioner has identified is one hour away from Petitioner's residence.
- c. [REDACTED] stated that there are no providers in Humana's network in Petitioner's area that are able to diagnose Petitioner's [REDACTED]. [REDACTED] stated that there are many providers in other cities, but those nearby do not accept Humana.
- d. [REDACTED] stated that the lack of access to providers and services is at issue. [REDACTED] [REDACTED] also stated that Humana cannot provide the services needed within a reasonable distance.
- e. [REDACTED] stated that nearby providers capable of providing assistance are within network of Sunshine Health Plan ("Sunshine"), SimplyHealthcare ("Simply"), or Children's Medical Services ("CMS").

9. Ms. Chillari is a Medical/Health Care Program Analyst with the Agency. Ms. Chillari testified to the following at the Fair Hearing:

- a. On [REDACTED], Petitioner requested a For Cause plan change due to a need to see an out of network provider.

- b. On [REDACTED], the Agency requested any related notices from Humana and received a Grievance Acknowledgement Letter and a Grievance Resolution Letter from the plan.
- c. On [REDACTED], Petitioner's For Cause plan change request was denied.
- d. On [REDACTED], the Agency issued to Petitioner a letter of Denial of For Cause Plan Change.
- e. On January 23, 2023, Petitioner requested a Fair Hearing regarding the denial of a disenrollment request.

CONCLUSIONS OF LAW

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

11. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

12. Because Petitioner is requesting a change of managed medical care plans outside of their enrollment period, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.).

13. Fla. Admin. Code R. 59G-8.600 governs Disenrollment from Managed Care Plans. It states the following:

(1) Purpose. A Florida Medicaid recipient (herein referred to as an enrollee) who is required to enroll in the Statewide Medicaid Managed Care (SMMC) Managed

Medical Assistance (MMA) or Long-term Care (LTC) program, may request to change managed care plans. Requests must be submitted via telephone to the Agency for Health Care Administration (AHCA) or its enrollment broker. Enrollees required to enroll in SMMC programs should not interpret this rule as an exemption from participation in Florida Medicaid's SMMC program. This rule applies to the process and reasons that SMMC managed care plan enrollees may change plans.

(2) Requests for disenrollment must be completed in accordance with sections 409.969, Florida Statutes (F.S.), and Title 42, Code of Federal Regulations (CFR), section 438.56 (42 CFR 438.56).

(3) For Cause Reasons.

(a) Reasons outlined in 42 CFR 438.569(d)(2) and Section 409.969(2), F.S., constitute cause for disenrollment at any time from a managed care plan:

1. The managed care plan does not cover the service the enrollee seeks because of moral or religious objections.
2. The enrollee would have to change his or her residential or institutional provider based on the provider's change in status from an in-network to an out-of-network provider with the managed care plan.

3. Fraudulent enrollment.

(b) Reasons outlined in 42 CFR 438.56(d)(2) and Section 409.969(2), F.S., constitute cause for disenrollment from a managed care plan when the enrollee first seeks resolution through the managed care plan's grievance process, as confirmed by AHCA, in accordance with 42 CFR 438.56(d)(5), except when there is an allegation of immediate risk of permanent damage to the enrollee's health:

1. The enrollee needs related services to be performed concurrently, but not all related services are available within the managed care plan's network, and the enrollee's primary care provider or another provider has determined that receiving the services separately would subject the enrollee to unnecessary risk.

2. Poor quality of care.

3. Lack of access to services covered under the managed care plan's contract with AHCA, including lack of access to medically-necessary specialty services.

4. There is a lack of access to managed care plan providers experienced in dealing with the enrollee's health care needs.

5. The enrollee experienced an unreasonable delay or denial of service pursuant to section 409.969(2), F.S.

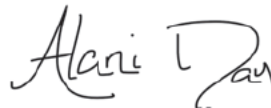
14. In this case, the evidence admitted and testimony presented is insufficient to support a *de novo* reversal of the Agency's decision, and establishes that the Petitioner's request cannot be granted. Here, Petitioner bears the burden of proof. As provided by statute, a For Cause plan change is permissible when "the enrollee needs related services to be performed concurrently, but not all related services are available within the managed care plan's network, and the enrollee's primary care provider or another provider has determined that receiving the services separately would subject the enrollee to unnecessary risk" (Rule 59G-8.600(3)(b)1). Statute also provides that Petitioner must "first [seek] resolution through the managed care plan's grievance process, as confirmed by AHCA" (Rule 59G-8.600(3)b). In the instant case, Petitioner sought resolution through the managed care plan's grievance process. See supra ¶ 3. Humana's Grievance Resolution Letter stated that ██████████ "declined additional assistance" from the plan. See supra ¶ 3. Given that ██████████ declined additional assistance from Humana, Humana did not have the opportunity to assist ██████████ in locating a suitable provider. As such, Petitioner has not demonstrated that "[not] all related services are available within the managed care plan's network" (Rule 59G-8.600(3)(b)1). Humana also reached out to Petitioner to provide assistance on multiple occasions. See supra ¶ 3. As such, the action taken by Humana is appropriate. See supra ¶ 3. Furthermore, ██████████ provided no evidence corroborating ██████████ claims regarding the distance between ██████████ residence and the providers about which ██████████ testified, nor did ██████████ provide evidence that the nearby providers are only in-network of the plans about which ██████████ testified. Accordingly, the undersigned finds that Petitioner did not prove by a

preponderance of the evidence that Respondent's denial of Petitioner's For Cause disenrollment request was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of Petitioner's For Cause disenrollment request is **AFFIRMED**.
Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 5th day of April, 2023, in Tallahassee, Leon County, Florida.



Alani Day
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ALANI DAY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com