

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



FILED

Feb 10, 2023, 9:12 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0178

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 9, 2023, at 9:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Lee Ann Williams
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. Petitioner was present for the hearing but did not participate.

Lee Ann Williams (“Ms. Williams”), Medical/Health Care Program Analyst and Fair Hearings Liaison with the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent.

The following persons appeared as observers: Doris Rivera, Medical/Health Care Program Analyst with the Agency and Joseph Mabry, Hearing Officer with the Office of Fair Hearings.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a twenty-one (21) page evidence packet. The twenty-one (21) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “23-FH0178- AHCA evidence 21 pgs.pdf”. Absent an objection from Petitioner, the undersigned admitted the twenty-one (21) page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of MCNA Dental Plan (“MCNA”). See page 11 of RCE 1. MCNA is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On [REDACTED], MCNA issued to Petitioner’s Authorized Representative a Member Grievance Acknowledgement Letter acknowledging Petitioner’s grievance. *Id.* at 11-15. On [REDACTED], MCNA issued to Petitioner’s Authorized Representative a Member Grievance Determination Letter, which contained the results of a facility search conducted by the Plan. *Id.* at 16-21.
3. On January 26, 2023, Petitioner’s Authorized Representative requested to change Petitioner’s Medicaid plan from MCNA to DentaQuest of Florida, Inc. (“DentaQuest”). See page

1 of RCE 1. Petitioner requested the change due to the lack of access to managed care plan providers experienced in dealing with the enrollee’s health care needs. *Id.* On January 30, 2023, the Agency denied the request because the facility search conducted by the Plan “was deemed appropriate – as outlined in the Plan’s Grievance Resolution Letter. (See Rule 59G-8.600(3)(b)(4)).” *Id.* at 1-2. MCNA’s Grievance Determination Letter stated as follows in pertinent part:

We performed a facility search and located the following participating dental providers in your area that are accepting new patients:

[REDACTED]

[REDACTED]

(Time: 1 hour 3 minutes | Distance: 40.7 miles)

...

Pages 16 – 17 of RCE 1.

4. On January 30, 2023, Petitioner’s Authorized Representative requested a Fair Hearing on behalf of Petitioner regarding the denial of a disenrollment request. *Id.* at 1. On February 8, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, scheduling the hearing for February 9, 2023, at 9:00 a.m. EST.

5. On January 31, 2023, the Agency issued a letter of Denial of For Cause Plan Change to Petitioner. *Id.* at 2. The letter explained the reason for the denial as follows:

The reason given for the requested For Cause plan change, outside of your Open Enrollment period, was there is a lack of access to managed care plan providers experienced in dealing with the enrollee’s health care needs. 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.

...

6. [REDACTED] is the [REDACTED] of the Petitioner. [REDACTED] testified at the Fair Hearing to the following:

- a. Petitioner's current plan, MCNA, does not have a [REDACTED] in [REDACTED] county.
- b. The provider located by MCNA is more than an hour away from Petitioner's residence and is located within another county.

7. Ms. Williams is a Medical/Health Care Program Analyst and Fair Hearings Liaison with the Agency. Ms. Williams testified at the Fair Hearing to the following:

- a. Petitioner was not willing to work with the Plan to locate a suitable provider.
- b. Petitioner had identified another provider that accepted another plan, according to the Plan's Grievance Determination Letter, and that dentist was Petitioner's preference.
- c. The Plan performed a facility search and located a provider for Petitioner, which Petitioner refused.
- d. Specialists, such as the one Petitioner is seeking, are contractually permitted to be located at a further distance.
- e. Petitioner is not in a period of disenrollment.

CONCLUSIONS OF LAW

8. 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).

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

10. 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.).

11. 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 damaged 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.

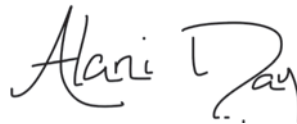
12. In this case, the evidence admitted and testimony presented is sufficient to support a *de novo* reversal of the Agency's decision, and establishes that the Petitioner's request can be granted. Here, Petitioner bears the burden of proof. As provided by statute, a For Cause plan change is permissible if there is a lack of access to managed care plan providers experienced in dealing with the enrollee's health care needs (Rule 59G-8.600(3)(b)(4)). Petitioner's Authorized Representative demonstrated lack of access to a [REDACTED] through sworn testimony and documentation from MCNA. [REDACTED] testified that MCNA's provider is located within another county and is over an hour away from Petitioner's residence. See supra ¶ 6. This was confirmed in MCNA's Grievance letter, which stated that a provider was available more than 40 miles from Petitioner's residence. See ¶ 3. Ms. Williams testified that specialists are contractually permitted a longer distance, but no documentation was provided informing these distancing

guidelines. See supra ¶ 7. As shown by the record, Petitioner does indeed lack access to providers within a reasonable distance from Petitioner's place of residence based upon the substantial distance between the Petitioner and the provider presented by MCNA in the Member Grievance Determination Letter. Accordingly, the undersigned finds that Petitioner proved 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 **REVERSED**.
Petitioner's appeal based on Respondent's denial is **GRANTED**.

DONE and ORDERED this 10th day of February, 2023, in Tallahassee, Leon County, Florida.



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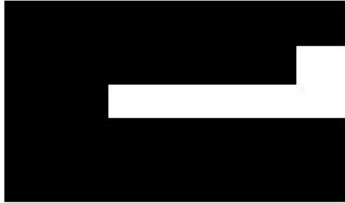
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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