



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

FILED

Jun 20, 2023, 11:55 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0670

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on May 2, 2023, at 2:32 p.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 Healthcare Administration (“Agency” or “AHCA”), appeared on behalf of Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner an eighteen (18) page evidence packet. The eighteen (18) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “Agency [REDACTED] Evidence Packet 23-FH0670.pdf”. Absent an objection from Petitioner, the undersigned admitted the eighteen (18) page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Liberty Dental Plan, Inc. (“Liberty”). See page 12 of RCE 1. Liberty is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On [REDACTED], Liberty issued to [REDACTED] a Grievance Response Notice. *Id.* at 14.

The letter reads as follows in pertinent part:

Below are offices in your area to choose from. If you would like to change [Petitioner’s] assigned office, please give the Plan a call.

[REDACTED]

...

Page 14 of RCE 1.

3. On [REDACTED], [REDACTED] requested to change Petitioner's Medicaid plan from Liberty to MCNA Dental, Inc. ("MCNA"). *Id.* at 1. [REDACTED] requested the change due to poor quality of care. *Id.*

4. On March 27, 2023, the Agency reviewed and denied the request because "the grievance process is complete and the action taken by the plan is deemed appropriate". *Id.* at 2, 3, 17. Also on March 27, 2023, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 2, 18.

5. On March 28, 2023, the Agency issued to [REDACTED] a letter of Denial of For Cause Plan Change. *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 Poor Quality of Care. 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.

6. On April 11, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for May 2, 2023, at 2:30 p.m. EST.

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

a. [REDACTED] testified that Petitioner's provider has stated to Petitioner and [REDACTED] that Medicaid does not pay her enough and that she takes Medicaid for

charity. [REDACTED] also stated that Petitioner's current provider claimed that she provided sealants to Petitioner when she had actually provided a fluoride wash. These instances demonstrate poor quality of care.

- b. The provider [REDACTED] would like to use either does not accept Liberty or is not currently taking patients from Liberty. This preferred provider does accept MCNA.
- c. [REDACTED] attempted to contact the Health Department listed in the Grievance Resolution letter, but [REDACTED] was never able to reach anyone. The other providers listed by the plan in the Grievance Resolution letter are forty-five (45) minutes away, and therefore too far from [REDACTED] residence.

8. 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], [REDACTED] requested a plan change due to poor quality of care.
- b. On [REDACTED], Liberty submitted to the Agency the Grievance Resolution Letter dated [REDACTED].
- c. On March 27, 2023, [REDACTED] request was denied because the Grievance process is complete and the action taken by the plan is deemed appropriate. [REDACTED] requested a Fair Hearing.
- d. On March 28, 2023, the For Cause denial letter was issued to [REDACTED].

CONCLUSIONS OF LAW

9. 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).

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

11. 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.).

12. 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.

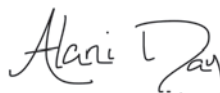
13. In this case, the evidence admitted and testimony presented is insufficient to support a *de novo* reversal of the Agency's decision, and establishes that the Petitioner's request cannot be granted. Here, Petitioner bears the burden of proof. As provided by statute, a For Cause plan change is permissible when the enrollee experiences "poor quality of care" (Rule 59G-8.600(3)(b)2). However, the enrollee must "first [seek] resolution through the managed care plan's grievance process" (Rule 59G-8.600(3)b). In the instant case, ██████████ sought resolution through Liberty's grievance process, evidenced by the Grievance Response Notice dated ██████████. See supra ¶ 2. Liberty's response located three (3) providers for Petitioner to visit. *Id.* While ██████████ has demonstrated through testimony the poor quality of care provided by Petitioner's previous dentist, ██████████ has not demonstrated poor quality of care from each provider listed in Liberty's Grievance Response Notice. ██████████ testified that the

listed providers were too far from [REDACTED] residence. See supra ¶ 7. This piece of testimony lends itself to an assertion of lack of access to providers. However, lack of access is not the For Cause reason [REDACTED] entered when requesting a For Cause disenrollment of the Agency. As such, the circumstances of Petitioner's case must be evaluated based upon whether Liberty's response to [REDACTED] grievance can be deemed insufficient due to the demonstration of poor quality of care. In the instant case, [REDACTED] did not demonstrate that Liberty's response was not appropriate, as [REDACTED] has not experienced poor quality of care from the listed providers. Specifically, under Rule 59G-8.600(3)(b)2, Petitioner's request cannot be granted. 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 20th day of June, 2023, in Tallahassee, Leon County, Florida.



Alani Day
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2023.06.20 10:45:27 -04'00'

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