



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

**FILED**

Jul 27, 2023, 9:04 am

OFFICE OF FAIR HEARINGS

████████████████████,

PETITIONER,

AHCA Case No.: 23-FH0958

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 30, 2023, at 9:02 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

██████████

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 ██████████

██████████ (“██████████”), appeared on behalf of the Petitioner. Petitioner appeared as a witness.

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

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a three (3) page evidence packet. The three (3) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “23-FH0958 Supporting Document.pdf”. Absent an objection from Respondent, the undersigned admitted the three (3) page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a seventeen (17) page evidence packet. The seventeen (17) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “23-FH0958-Agency Evidence 17 pgs.pdf”. Absent an objection from Petitioner, the undersigned admitted the seventeen (17) 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 (“MCNA”). *See* page 12 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], [REDACTED] requested to change Petitioner’s Medicaid plan from MCNA to DentaQuest of Florida, Inc. (“DentaQuest”). *Id.* at 1. [REDACTED] requested the plan change due to the lack of access to managed care plan providers experienced in dealing with the enrollee’s health care needs. *Id.*

3. On April 20, 2023, MCNA issued to [REDACTED] a Grievance Determination Letter. *Id.* at

12. The letter reads as follows in pertinent part:

Our records show that on March 2, 2023, a grievance was received from you for disenrollment. You stated that your provider only accepts DentaQuest and you were advised of the grievance/disenrollment process. The Grievance and Appeals Administrator conducted a search within 35 miles of your home. The dental facilities noted below were contacted.

[REDACTED]

The next available appointment was for [REDACTED].  
Time/Distance: [REDACTED]

[REDACTED]

The next available appointment was for [REDACTED].  
Time/Distance: [REDACTED]

[REDACTED]

The next available appointment was for [REDACTED].  
Time/Distance: [REDACTED]

...

On April 5, 2023, a Call Center Supervisor contacted you via telephone. You stated that [Petitioner] needs to have [REDACTED] wisdom teeth removed because they are causing [REDACTED] [REDACTED] due to [REDACTED]. You requested to change [Petitioner's] dental plan from MCNA because the oral surgeon who can do the procedure is not accepting the current plan and you cannot wait until open enrollment. You stated that you were given a list of providers that are in-network but the closest provider is about 2 and a half hours away. The supervisor apologized to you for your experience and advised that your concerns were documented. The supervisor offered to find a list of providers who accept [Petitioner's] plan, but you declined.

...

Pages 12 and 13 of RCE 1.

4. On April 21, 2023, the Agency contacted MCNA to obtain a copy of the Grievance Determination Letter. *Id.* at 1.

5. On April 26, 2023, the Agency denied the request upon review of the Grievance Determination Letter because the action taken by the Plan was deemed appropriate. *Id.* at 1, 2, 9.

6. On April 27, 2023, the Agency issued to [REDACTED] a letter of Denial of For Cause Plan Change. *Id.* at 2. 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 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.

...

Page 2 of RCE 1.

7. On April 28, 2023, Petitioner requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On May 9, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for May 30, 2023, at 9:00 a.m. EST.

8. On May 22, 2023, Petitioner submitted to the Office of Fair Hearings a referral for the removal of wisdom teeth. *See* pages 2 and 3 of PCE 1.

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

- a. Petitioner has [REDACTED] of [REDACTED] care and switched to an [REDACTED] dentist.
- b. [REDACTED] stated that Petitioner needed to change providers only, but Petitioner's plan was also switched from DentaQuest to MCNA. [REDACTED] stated that Petitioner's plan should not have been changed.

- c. Petitioner has received a referral for the removal of [REDACTED] wisdom teeth. The only surgeon in Petitioner's city who performs this surgery accepts only the DentaQuest plan. The MCNA surgeon is located more than two (2) hours away in another city. [REDACTED] [REDACTED] stated that Petitioner does not have transportation.
  - d. Of the providers listed by MCNA in the Resolution letter, none is an oral surgeon. [REDACTED] stated [REDACTED] reached out to the plan after receiving this letter to explain that Petitioner did not need a dental provider, but rather a surgeon.
  - e. In response to a question from Respondent, [REDACTED] stated [REDACTED] received a letter dated December 15, 2022, reflecting a plan change request made on December 14, 2022, to MCNA.
10. Ms. Williams is a Medical/Health Care Program Analyst with the Agency. Ms. Williams testified to the following at the Fair Hearing:
- a. On April 19, 2023, Petitioner requested a plan change.
  - b. On April 26, 2023, upon review of the plan's Resolution letter, the Agency denied Petitioner's request because the Plan's action was deemed appropriate.
  - c. On April 27, 2023, a For Cause denial letter was issued to Petitioner.
  - d. On April 28, 2023, Petitioner requested a Fair Hearing.
  - e. Petitioner received a letter dated December 15, 2022, which reflects a plan change to MCNA requested on December 14, 2022.
  - f. MCNA listed three providers for Petitioner. Petitioner declined an offer from MCNA to locate suitable providers.

**CONCLUSIONS OF LAW**

11. 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).

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

13. 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.).

14. 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.

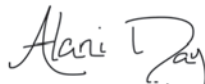
15. In this case, the evidence admitted and testimony presented is insufficient to support a *de novo* reversal of the Agency's decision, and establishes that the Petitioner's request cannot be granted. Here, Petitioner bears the burden of proof. As provided by statute, a For Cause plan change is permissible when "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). 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, Petitioner sought resolution through MCNA's grievance process, evidenced by the Grievance Determination Letter dated April 20, 2023. See supra ¶ 3. ■■■.

██████████ testified that Petitioner does not have transportation to visit MCNA's surgeon. See supra ¶ 9. However, Petitioner has access to the dental plan's transportation services, and can use these services to visit MCNA's surgery provider. ██████████ further stated that Petitioner's dental plan should not have been changed. *Id.* However, Respondent stated that ██████████ received a letter on December 15, 2022, which reflects a plan change request made on December 14, 2022, to MCNA. See supra ¶ 10. ██████████ stated ██████████ received this letter. See supra ¶ 9. The letter not only represents a request to change plans, but also provides an opportunity to change plans before the enrollment cut-off date listed on the letter. ██████████ did not change Petitioner's plan to DentaQuest before the enrollment cut-off date upon receipt of this letter. 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 27th day of July, 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**