



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

FILED

Jul 21, 2023, 2:26 pm

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1022

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 7, 2023, at 2:27 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 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 five (5) pages of documents. These five (5) pages of documents appear in the Office of Fair Hearings’ document management system as file title “[Petitioner] Fair Hearing request.pdf”. Absent an objection from Respondent, the undersigned admitted the five (5) pages of documents into evidence as Petitioner’s Exhibit 1 (“PE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a sixteen (16) page evidence packet. The sixteen (16) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “Agency [REDACTED] Evidence Packet 23-FH1022.pdf”. Absent an objection from Petitioner, the undersigned admitted the sixteen (16) 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, Inc. (“MCNA”). See page 13 of RCE 1 and page 2 of PE 1. MCNA is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On April 21, 2023, [REDACTED] filed a grievance with MCNA. *Id.*
3. On April 21, 2023, [REDACTED] requested to change Petitioner’s Medicaid plan from MCNA to an unspecified dental plan. See page 2 of RCE 1. [REDACTED] requested the change due to the lack of access to providers experienced with specific needs. *Id.* The Agency auto-denied the request due to the response of “no” to the question, “Has the member filed a grievance with the plan?”. *Id.* at 2, 11.

4. On April 24, 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 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 enrollee failed to go through the managed care plan's Grievance process as required (See Rule 59G-8.600(3)(b)4).

...

Page 3 of RCE 1.

5. On May 4, 2023, [REDACTED] submitted an e-mailed Fair Hearing request regarding the denial of a For Cause disenrollment request. *Id.* at 2. On May 16, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for June 7, 2023, at 2:30 p.m. EST.

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

- a. [REDACTED] stated that Petitioner needs a [REDACTED] in order to get x-rays and dental cleanings due to Petitioner's [REDACTED] [REDACTED] contacted two (2) providers whose waiting lists were nine (9) months and one (1) year long. [REDACTED] stated that this was too long of a wait.
- b. [REDACTED] found a dentist who practices [REDACTED] in [REDACTED] area and paid out of pocket for x-rays, as this provider only takes DentaQuest. [REDACTED] wants to remain with this provider.

c. ██████ filed a Grievance with ██████ plan. ██████ stated that ██████ must have received a Grievance Resolution from MCNA because ██████ had reached the point of the Fair Hearing, but ██████ was not able to locate a Grievance Resolution Letter.

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

a. On April 21, 2023, ██████ requested a plan change. The request was auto-denied by the Agency due to the response of “no” to the question asking if a grievance had been filed.

b. On April 24, 2023, the Agency issued to ██████ a For Cause denial letter, which stated that ██████ request was denied because ██████ failed to go through MCNA’s grievance process.

c. On May 4, 2023, ██████ requested a Fair Hearing.

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 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.

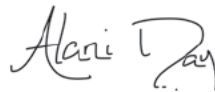
12. In this case, the evidence admitted and testimony presented is insufficient to support a *de novo* reversal of the Agency's decision, and establishes that the Petitioner's request cannot be granted. Here, Petitioner bears the burden of proof. As provided by statute, a For Cause plan change is permissible 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, [REDACTED] has not completed MCNA's Grievance process. [REDACTED] filed a grievance with the plan, and [REDACTED] submitted as evidence the Member Grievance Form [REDACTED] completed. See supra ¶ 2. However, no Grievance Resolution letter was provided, and this letter signals completion of the Grievance process. [REDACTED] testified that [REDACTED] must have received a Grievance Resolution letter, but could not locate it. See supra ¶ 6. However, as there is no proof nor confirmation of receipt of a Grievance Resolution letter, [REDACTED] has not completed the Grievance process through to resolution, as is required before requesting a For Cause plan change. As such, the Agency appropriately denied Petitioner's request. 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 21st day of July 2023, in Tallahassee, Leon County, Florida.



Alani Day
23-FH1022
2023.07.21 10:14:39 -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