



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

FILED

Sep 11, 2023, 10:28 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1410

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on July 11, 2023, at 2:02 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.

Petitioner did not introduce any exhibits at the hearing. 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 SOM Evidence Packet 23-FH1410.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 Community Care Plan, Inc. (“CCP”). *See* pages 12 and 13 of RCE 1. CCP is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. On May 16, 2023, CCP issued to Petitioner a Determination of Grievance Letter. *Id.* at 13.

The letter reads as follows in pertinent part:

Based on your conversation with one of our Customer Experience Coordinators, you stated that you would like to disenroll with Community Care Plan in order to enroll with Sunshine Health Plan. However, in the meantime, you requested us to locate two in-network Pediatric Psychologists in your area. The following doctors were sent to your e-mail address at [REDACTED]:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

...

Page 13 of RCE 1.

3. On May 23, 2023, [REDACTED] requested to change Petitioner's Medicaid plan from CCP to Sunshine Health Plan ("Sunshine"). *Id.* at 1. Petitioner requested the change due to the lack of access to services covered under contract with AHCA. *Id.*

4. Also on May 23, 2023, CCP submitted to the Agency the Determination of Grievance Letter dated May 16, 2023. *Id.*

5. On June 1, 2023, the Agency reviewed and denied [REDACTED]'s request because the action taken by the plan was deemed appropriate. *Id.* at 1, 2, 3.

6. On June 2, 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 lack of access to services covered under the managed care plan's contract with AHCA, including lack of access to medically-necessary specialty services. 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.

Once per year, members may change their SMMC plans during Open Enrollment if they do not otherwise qualify for a For Cause plan change. The Enrollee's next Open Enrollment period will begin on **10/01/2023**.

...

Page 3 of RCE 1.

7. On June 13, 2023, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On June 22, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for July 11, 2023, at 2:00 p.m. EST.

8. On June 27, 2023, Respondent sent to the Office of Fair Hearings a sixteen (16)-page evidence packet. Included in the packet was Petitioner's For Cause Request/Questionnaire. *Id.* at

10. The questionnaire reads as follows in pertinent part:

What service is the member unable to access in their current plan?

Music therapy

What reason was given for why the member cannot access the service in the member's current plan?

█ stated it does not state. That the office for music therapy only takes Sunshine health.

...

Page 10 of RCE 1.

9. █ is the █ of the Petitioner. █ testified to the following at the

Fair Hearing:

- a. █ stated that Petitioner is diagnosed with █.
- b. █ is seeking a plan change to Sunshine because █ heard this plan has better coverage regarding music therapy and mental health services. There is a music school which offers music therapy, but this school only accepts Sunshine.
- c. █ stated that the two mental health providers listed in the Determination of Grievance Letter either only treat adult patients or do not accept CCP.
- d. █ testified that █ has not spoken to █ plan about a music therapist that would be in-network.

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

- a. On May 23, 2023, [REDACTED] requested a plan change from CCP to Sunshine due to lack of access to services covered under contract with AHCA. [REDACTED]'s request was related to accessing music therapy for Petitioner.
- b. On May 23, 2023, the Agency requested of CCP any pertinent Grievances or notices. CCP submitted to the Agency the Determination of Grievance Letter dated May 16, 2023.
- c. On June 1, 2023, the Agency denied [REDACTED]'s request because the action taken by the plan was appropriate.
- d. On June 2, 2023, the Agency issued a For Cause denial letter to [REDACTED]. The letter stated that the request was denied because the Grievance process is complete and the action taken by the plan is deemed appropriate, as outlined in the Grievance Resolution letter.
- e. On June 13, 2023, [REDACTED] requested a Fair Hearing.

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 the enrollee experiences a "lack of access to services covered under the managed care plan's contract with AHCA, including lack of access to medically-necessary specialty services" (Rule 59G-8.600(3)(b)3). 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]'s Grievance regarding mental health providers has been resolved by CCP, evidenced by the Determination of Grievance Letter dated May 16, 2023. *See supra* ¶ 2. [REDACTED] testified that the two mental health providers listed on the letter either only treat adult patients or are not in CCP's network. *See supra* ¶ 9. However, [REDACTED] requested a plan change, evidenced by the For Cause Request/Questionnaire, because the music therapy provider [REDACTED] located does not accept CCP. *See supra* ¶¶ 8, 10. Respondent's evidence packet indicates that [REDACTED] requested the plan change because the music therapy provider only accepts Sunshine. *Id.* As such, there is a discrepancy between the issue resolved in [REDACTED]'s Grievance and the reason for [REDACTED]'s plan change request. The Determination of

Grievance Letter states that [REDACTED] “requested [CCP] to locate two in-network Pediatric Psychologists.” See supra ¶ 2. There is no mention of music therapy providers in this Grievance. [REDACTED] also testified that [REDACTED] did not ask [REDACTED] current plan if there was a music therapist in CCP’s network. See supra ¶ 9. As such, [REDACTED] has not completed the required Grievance process regarding the music therapy services for which [REDACTED] requested the plan change. While [REDACTED] has completed the Grievance process regarding mental health services, [REDACTED]’s For Cause plan change request with the Agency was based on services for which [REDACTED] had not completed the Grievance process. 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 11th day of September, 2023, in Tallahassee, Leon County, Florida.



Alani Day
23-FH1410
2023.09.11 07:57:25 -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:

[REDACTED]
[REDACTED]

**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**