



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

**FILED**

Nov 14, 2023, 11:36 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2013

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on September 25, 2023, at 1:58 p.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson

Registered Nurse Specialist

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.

Linda Latson (“Ms. Latson”), Registered Nurse Specialist 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 twenty-five (25)-page evidence packet. The twenty-five (25)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “23-FH2013 Fair Hearing Exhibits.pdf”. Absent an objection from Respondent, the undersigned admitted the twenty-five (25)-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 twenty-five (25)-page evidence packet. The twenty-five (25)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “Agency SOM Evidence Packet 23-FH2013.pdf”. Absent an objection from Petitioner, the undersigned admitted the twenty-five (25)-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 pages 16 and 17 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 [REDACTED] a Grievance Determination Letter. *Id.* at 17.

The letter reads as follows in pertinent part:

We were able to locate in-network dental offices that are within 35 miles of your home residence.

[REDACTED]

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

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

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

...

Pages 17 and 18 of RCE 1.

3. On August 9, 2023, MCNA issued to [REDACTED] another Grievance Determination Letter.

See page 16 of PCE 1. The letter reads as follows in pertinent part:

After escalation to our Provider Relations Department, MCNA has not been successful in finding an in network oral surgeon who will treat an [REDACTED]. At this time, **MCNA does not have a provider that can assist with the service needed.**

Our Provider Relations Department have researched and called the same providers in the network with Liberty since you requested to change to Liberty. After a further search of the network, DentaQuest and Liberty have the same Oral Surgeons as the MCNA's network except for the facility [REDACTED]. We contacted the office on [REDACTED], but the office does not see patients under [REDACTED].

...

Page 16 of PCE 1. (Emphasis added).

4. On August 16, 2023, [REDACTED] requested a Fair Hearing to change Petitioner's Medicaid dental plan. See pages 1 and 10 of RCE 1.

5. On August 18, 2023, the Agency submitted a request to dismiss the Fair Hearing request, citing lack of a For Cause Denial on file. *Id.* at 1, 11.

6. On August 22, 2023, [REDACTED] submitted a follow-up hearing request. *Id.* at 1, 12. [REDACTED] also requested a For Cause plan change of the Agency from MCNA to Liberty Dental Plan (“Liberty”). *Id.* at 1, 14. The Agency requested of MCNA any grievances or letters issued to Petitioner. *Id.* at 2, 15.

7. On August 23, 2023, MCNA submitted to the Agency the Grievance Resolution dated [REDACTED]. *Id.* at 2, 17.

8. On August 25, 2023, the Agency reviewed and denied Petitioner’s request because the Grievance process was complete and the action taken by the plan was deemed appropriate. *Id.* at 2.

9. On August 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 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 3 of RCE 1.

10. On August 31, 2023, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 2. On September 6, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for September 25, 2023, at 2:00 p.m. EST.

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

- a. [REDACTED] stated that Petitioner needs [REDACTED]. [REDACTED] stated that [REDACTED] has been looking for a specialty surgeon since [REDACTED] to perform the surgery.
- b. MCNA was unsuccessful in locating a provider to perform the surgery. [REDACTED] testified that several providers [REDACTED] visited or spoke to could not perform the procedure. [REDACTED] testified that other providers were located more than two (2) hours away.
- c. [REDACTED] testified that Petitioner has been experiencing [REDACTED].
- d. [REDACTED] stated [REDACTED] has found a provider in Liberty's network to provide the surgery.

12. Ms. Latson is a Registered Nurse Specialist with the Agency. Ms. Latson testified to the following at the Fair Hearing:

- a. On August 16, 2023, [REDACTED] requested a Fair Hearing to change dental plans.
- b. On August 18, 2023, the Agency submitted a request to dismiss the hearing, citing lack of a For Cause denial letter on file.
- c. On August 22, 2023, [REDACTED] sent a follow-up hearing request to the Agency. [REDACTED] also requested a For Cause plan change from MCNA to Liberty.
- d. On August 23, 2023, MCNA submitted to the Agency the Grievance Resolution dated [REDACTED].
- e. On August 25, 2023, the Agency reviewed and denied Petitioner's request because the Grievance process was complete and the action taken by the plan was deemed appropriate.

- f. On August 28, 2023, the Agency issued to [REDACTED] the For Cause denial letter.
- g. On August 31, 2023, [REDACTED] submitted to the Agency another Fair Hearing request.

### **CONCLUSIONS OF LAW**

13. 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).

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

15. 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.).

16. 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.

17. 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 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, Petitioner

must “first [seek] resolution through the managed care plan’s grievance process.” (Rule 59G-8.600(3)b). In the instant case, Petitioner has completed the required Grievance process. MCNA’s Grievance Determination Letter dated August 9, 2023, stated that “MCNA does not have a provider that can assist with the service needed.” See supra ¶ 3. As Petitioner’s current plan has confirmed that it does not have providers for Petitioner, and as the plan did not dispute the necessity of the services, Petitioner has demonstrated a lack of access to providers. MCNA also stated that, “after a further search of the network, DentaQuest and Liberty have the same Oral Surgeons as the MCNA’s network except for the facility [REDACTED]. [MCNA] contacted the office on [REDACTED], but the office does not see patients under [REDACTED].” See supra ¶ 3. However, [REDACTED] testified that [REDACTED] located a different provider who accepted the Liberty plan who would be able to provide the necessary services. See supra ¶ 11. As MCNA has confirmed Petitioner’s lack of access to providers, Petitioner’s circumstances satisfy the conditions for a For Cause disenrollment outside of the Open enrollment period. 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 14th day of November, 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:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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