



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

FILED

Apr 29, 2024, 3:49 pm
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 24-FH0298

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 28, 2024, at 9:06 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
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.

Marielisa Amador (“Ms. Amador”), 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 twenty-four (24)-page evidence packet. The twenty-four (24)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “24-FH0298 AHCA evidence.pdf”. Absent an objection from Petitioner, the undersigned admitted the twenty-four (24)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply Healthcare Plan. (“Simply”). See page 13 of RCE 1. Simply is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. On January 18, 2024, Simply issued to Petitioner a Grievance Acknowledgement Letter. *Id.* at 13. The letter reads as follows in pertinent part:

As your health plan, we commit to working with you to provide quality member service. Thank you for contacting Simply Healthcare Plans, Inc. with your grievance request. We received your grievance on 01/18/2024 and will review it within 90 calendar days of this date. After our review, we will send you a written response with the results.

...

Page 13 of RCE 1.

3. On January 18, 2024, [REDACTED] requested to change Petitioner’s Medicaid plan from Simply 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. On January 23, 2024, the Agency requested of Simply a copy of the Grievance Resolution letter. *Id.* Simply submitted a Grievance Acknowledgement Letter dated January 18, 2024, for a Grievance filed on January 18, 2024. *Id.* The Agency reviewed and denied Petitioner’s request for failure to complete the managed care plan’s Greivanec process as required. *Id.*

5. On January 24, 2024, the Agency issued to Petitioner 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 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 enrollee failed to go through the managed care plan’s Grievance process as required (See Rule 59G-8.600(3)(b)3).

...

Page 2 of RCE 1.

6. On January 30, 2024, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On February 13, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for February 28, 2024, at 9:00 a.m. EST.

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

a. [REDACTED] is seeking a plan change due to a hospital bill and due to an after-care program at Petitioner’s school accepting only the Sunshine plan. Petitioner [REDACTED] [REDACTED] Petitioner’s current plan is Simply. The hospital informed [REDACTED] that [REDACTED] owed a bill, but [REDACTED] provided Simply’s

information and the hospital stated they would talk to Simply. However, [REDACTED] received more bills in the mail, and [REDACTED] filed a Grievance.

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

- a. Petitioner requested a plan change from Simply to Sunshine due to lack of access to services covered under contract with AHCA. The Agency contacted Simply and requested the Grievance Resolution letter. Simply submitted a Grievance Acknowledgement letter dated January 18, 2024, which states that the Resolution may take up to ninety days. This was an administrative denial, as the Grievance process is not complete. [REDACTED] must wait for the plan's Resolution.
- b. If [REDACTED] received a bill, [REDACTED] may request a Letter of Credible Coverage from the Medicaid Help Line.

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 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.

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. *See supra* ¶ 11. 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] had not completed the required Grievance process through to Resolution prior to the For Cause disenrollment request of the Agency, as is required by statute. *See supra* ¶¶ 2, 3. Simply's Grievance Acknowledgement states that Petitioner's Grievance was received by the plan on January 18, 2024. *See supra* ¶ 2. Petitioner's For Cause disenrollment request with the Agency was also submitted on January 18, 2024. *See supra* ¶ 3. As such, Petitioner's Grievance was not resolved prior to the disenrollment request, and the required Grievance process is not complete. Furthermore, no evidence nor testimony was presented demonstrating an immediate risk of permanent damage to the enrollee's health. As such, Petitioner's circumstances do not satisfy the requirements for a For Cause disenrollment outside of the Open Enrollment period. 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 29th day of April, 2024, in Tallahassee, Leon County, Florida.



Alani Day
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2024.04.29 08:25:41 -04'00'

ALANI DAY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32408-5407

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