



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

FILED

Jun 03, 2024, 1:22 pm

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 24-FH0692

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 8, 2024, at 2:01 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

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 [REDACTED],

[REDACTED] (" [REDACTED] "), appeared on behalf of the Petitioner.

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 “24-FH0692 Evidence.pdf”. Absent an objection from Respondent, the undersigned admitted the three (3)-page evidence packet into evidence as Petitioner’s Exhibit 1 (“PE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a twenty-nine (29)-page evidence packet. The twenty-nine (29)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “24-FH0692-SOM.pdf”. Absent an objection from Petitioner, the undersigned admitted the twenty-nine (29)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine Health Plan. (“Sunshine”). *See* pages 14 and 20 of RCE 1. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On February 7, 2024, [REDACTED] requested to change Petitioner’s Medicaid plan from Sunshine to Molina Health Plan (“Molina”). *Id.* at 1.
3. On February 23, 2024, Sunshine issued to Petitioner a Grievance Resolution letter. *Id.* at 20. The Grievance Resolution letter reads as follows in pertinent part:

On 02/07/2024, we received your grievance about Limited Panel of Providers. The result of that review as of 02/23/2024 is:

We apologize for any inconvenience this may cause. If you need information regarding participating providers in the Sunshine Health network, please reach out to customer service at the telephone number on this letter. Sunshine Health has a large network of physicians and hospitals that were selected based on their ability to meet our high-quality standards and stringent requirements. We searched our network within the acceptable travel range allowed and confirmed with the provider(s) listed below, they accept new Sunshine Health patients at this time:

[REDACTED]

...

Page 20 of RCE 1.

4. On February 24, 2024, [REDACTED] filed a lack of access to providers experienced in dealing with specific needs. *Id.* at 1. [REDACTED] advised [REDACTED] wants to keep [REDACTED] current Pediatrician who no longer accepts Sunshine Health. *Id.*

5. On February 26, 2024, the Agency reviewed the request. *Id.* The For Cause reviewer contacted Sunshine to obtain a copy of the Grievance Resolution letter. *Id.* Upon review of the Resolution letter dated February 23, 2024, the request was denied because the action taken by the plan was deemed appropriate. *Id.*

6. On March 4, 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 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 March 5, 2024, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On March 19, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for April 8, 2024, at 2:00 p.m. EST.

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

a. [REDACTED] stated [REDACTED] needs to change from Sunshine to Molina, as Petitioner's provider no longer accepts Sunshine. The request was denied because there are other providers in network, but one was twenty minutes away, one was in [REDACTED], and one has bad reviews. [REDACTED] stated [REDACTED] is twenty minutes away from Petitioner's current provider, and [REDACTED]'s other [REDACTED] sees this provider as well. [REDACTED] is comfortable with and wants to keep the current provider.

b. [REDACTED] was notified in January that the provider did not accept Sunshine. [REDACTED] stated [REDACTED] called the providers listed on the Resolution letter, and one was at the wrong address, one was in [REDACTED], and one has bad reviews.

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

- a. On February 7, 2024, [REDACTED] requested a plan change from Sunshine to Molina, and the Grievance process was explained to [REDACTED].
- b. On February 24, 2024, [REDACTED] filed a lack of access to providers experienced with specific needs. [REDACTED] advised [REDACTED] wants to keep Petitioner's current Pediatrician who no longer accepts Sunshine. The request was sent to the Agency for review.
- c. On February 26, 2024, the Agency reviewed the request. The reviewer contacted Sunshine to obtain a copy of the Grievance Resolution letter. After review of the Resolution letter dated February 23, 2024, the request was denied because the action taken by the Plan was deemed appropriate, as outlined in the Plan's Grievance Resolution letter.
- d. On March 4, 2024, the For Cause denial letter was sent to [REDACTED]. On March 5, 2024, [REDACTED] requested a Fair Hearing.
- e. Sunshine's Resolution letter listed providers in [REDACTED]'s area, and Sunshine provided information regarding the distance from the providers. Sunshine advised that two providers were found for Petitioner, but [REDACTED] stated [REDACTED] would stay with the current provider.
- f. Petitioner's Open Enrollment period is from November 1, 2024, through December 31, 2024. Since the plan was able to find at least one participating provider in the area, the plan has met expectations.

CONCLUSIONS OF LAW

10. 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).

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

12. 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.).

13. 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.

14. 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* ¶ 12. 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] had not received a Grievance Resolution letter from Sunshine at the time of [REDACTED] For Cause disenrollment request, as required by statute. *See supra* ¶¶ 2, 3. Petitioner's plan change request was made on February 7, 2024,

whereas the Resolution letter from Sunshine was received on February 23, 2024. *Id.* As such, Petitioner did not “first [seek] resolution through the managed care plan’s grievance process, as confirmed by AHCA.” (Rule 59G-8.600(3)b). There may only be a departure from the required Grievance process “when there is an allegation of immediate risk of permanent damage to the enrollee’s health.” (Rule 59G-8.600(3)b). There is no allegation of immediate risk of permanent damage to the enrollee’s health in the instant case. Furthermore, Sunshine listed a provider, as testified to by [REDACTED], that is twenty minutes away from [REDACTED] residence. *See supra* ¶¶ 3, 8. As such, Petitioner has not demonstrated a lack of access to providers. 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 3rd day of June, 2024, in Tallahassee, Leon County, Florida.



Alani Day
24-FH0692
2024.06.03 08:31:39 -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:

[REDACTED]
[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com