



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

FILED

Jul 09, 2024, 12:19 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH1121

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 5, 2024, at 9:07 a.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 two (2)-page evidence packet. The two (2)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “24-FH1121 and 24-FH1123 Emailed Correspondence.pdf”. Absent an objection from Respondent, the undersigned admitted the two (2)-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 an eleven (11)-page evidence packet. The eleven (11)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “24-FH1121 SOM.pdf”. Absent an objection from Petitioner, the undersigned admitted the eleven (11)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of UnitedHealthcare of Florida. (“United”). *See* page 1 of RCE 1. United is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On March 22, 2024, [REDACTED] requested to change Petitioner’s Medicaid plan from United to Sunshine Healthcare Plan (“Sunshine”). *Id.* at 1. [REDACTED] stated the need for behavioral health services. *Id.* [REDACTED] indicated that [REDACTED] filed a Grievance with the plan on February 23, 2024. *Id.* Petitioner requested the change due to the lack of access to providers

experienced with specific needs. *Id.* The Agency contacted United to obtain a copy of the Grievance Resolution letter. *Id.*

3. On March 28, 2024, United responded and confirmed that no call was received on February 23, 2024, regarding behavioral health services or a Grievance filed. *Id.* The Agency denied Petitioner's request for failure to go through the managed care plan's Grievance process as required. *Id.* at 1.

4. On April 2, 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 enrollee failed to go through the managed care plan's Grievance process as required (See Rule 59G-8.600(3)(b)4).

...

Page 2 of RCE 1.

5. On April 8, 2024, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On May 9, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for June 5, 2024, at 9:00 a.m. EST.

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

a. [REDACTED] stated [REDACTED] has a balance due at Petitioner's counseling camp from last year when the camp stopped accepting United. [REDACTED] stated there was also counseling at school during the school year which helped with mental health, as Petitioner has

some anger. [REDACTED] stated that, since the provider does not accept United, the provider stopped seeing Petitioner at school. [REDACTED] stated the provider still sees [REDACTED], who have Sunshine. [REDACTED] stated the plan was accepted when [REDACTED] signed up, but the provider called later and stated they no longer accept United. [REDACTED] wants to send Petitioner to camp this year, but the camp still does not accept United.

- b. [REDACTED] stated [REDACTED] was told a Grievance was filed. [REDACTED] stated [REDACTED] received a Grievance reference number. In response to a question from Respondent, [REDACTED] confirmed that [REDACTED] did not receive an Acknowledgement letter.

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

- a. On March 22, 2024, [REDACTED] requested a plan change from United to Sunshine due to needing behavioral health services. [REDACTED] indicated that [REDACTED] had filed a Grievance with her plan on February 23, 2024. [REDACTED] selected the For Cause reason regarding lack of access to providers experienced with specific needs. The Agency contacted United to obtain a copy of the Grievance Resolution letter.
- b. On March 28, 2024, United confirmed that there was no call received on February 23, 2024, referencing behavioral health services or a Grievance filed. [REDACTED] request was denied because [REDACTED] failed to go through the managed care plan's Grievance process as required.

- c. On April 2, 2024, the For Cause denial letter was sent to [REDACTED]. On April 8, 2024, [REDACTED] requested a Fair Hearing. If [REDACTED] had filed a Grievance, [REDACTED] would have received an Acknowledgement letter.

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. *See supra* ¶ 10. 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 this case, the required Grievance process is not complete. [REDACTED] provided evidence that an appeal case was successfully created, but [REDACTED] has not received a Grievance Acknowledgement letter from the plan, indicating the start of the Grievance process. See supra ¶ 6. [REDACTED] also bears the burden of proof and did not submit evidence of a Grievance Resolution letter. As such, the required Grievance process is not complete. 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). Here, there is not an immediate risk of permanent damage to the enrollee’s health. Furthermore, [REDACTED] testified that [REDACTED] would like Petitioner to receive services from a particular provider, but [REDACTED] did not submit evidence that [REDACTED] lacks access to other in-network providers of behavioral services. 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 9th day of July, 2024, in Tallahassee, Leon County, Florida.



Alani Day
24-FH1121
2024.07.09 07:11:45 -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