FILED

Jul 10, 2024, 11:59 am

OFFICE OF FAIR HEARINGS

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

,

PETITIONER, **AHCA Case No.: 24-FH1272**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on May 21, 2024, at 9:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: 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 ,
(""), 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.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a fifteen (15)-page evidence packet. The fifteen (15)-page evidence packet appears in the Office of Fair Hearings' document management system as file title "24-FH1272 (FC) Hearing Evidence 15 Pages.pdf". Absent an objection from Petitioner, the undersigned admitted the fifteen (15)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of Liberty Dental Plan. ("Liberty"). *See* page 12 of RCE 1. Liberty is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. On March 29, 2024, Liberty issued to Petitioner a Grievance Acknowledgement Notice. *Id*. at 12. The notice reads as follows in pertinent part:

> The Plan received your grievance on March 28, 2024. You will get a letter in **30 days** from the date we received your grievance. If you have anything you would like to add to your case, please let us know right away.
> . . .

Page 12 of RCE 1.

3. On April 8, 2024, [redacted] requested to change Petitioner's Medicaid plan from Liberty to MCNA Dental Plan ("MCNA"). *Id*. at 1. [redacted] requested the change due to the lack of access to services covered under the contract with AHCA, including lack of access to medically necessary specialty services. *Id*.

4. On April 12, 2024, the Agency reviewed Petitioner's request, and Liberty provided a copy of the Grievance Acknowledgement letter dated March 29, 2024, for a Grievance filed on March 28, 2024. *Id*. No Grievance Resolution letter was provided by the plan. *Id*. The request was denied for failure to go through the managed care plan's Grievance process as required. *Id*.

5. On April 15, 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 the enrollee experienced an unreasonable delay or denial of service pursuant to Section 409.969(2), F.S. 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 Appeal process as required (See Rule 59G8.600(3)(b)5).
> . . .

Page 2 of RCE 1.

6. On April 19, 2024, requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id*. at 1. On May 6, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for May 21, 2024, at 9:00 a.m. EST.

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

a. stated Petitioner is diagnosed with stated has had difficulty finding providers to accommodate Petitioner's needs, and that the current plan does not have providers to meet Petitioner's needs. stated found a provider to meet Petitioner's needs, but a plan change would be needed.

b. stated Petitioner has previously had stated Petitioner stated Petitioner's provider could not treat Petitioner any longer because of Petitioner's movement. stated this provider recommended that Petitioner go to a specialist, and that Petitioner could not go back to pediatric dentist due to age.

c. stated called the numbers on Liberty's website, but some of the providers no longer accepted Liberty. stated found some in-network providers, but each one stated they do not accept adult patients. stated asked the Liberty providers if sedation dentistry was offered, but the providers did not specialize in sedation dentistry. stated has called several counties.

d. stated located a provider that specializes in working with people with , but that this provider does not accept Liberty. stated this provider accepts MCNA. asserted a lack of access to covered specialty services and a lack of access to providers. stated had not found a provider for Petitioner at the time of the last Open Enrollment period.

e. stated Petitioner has not been to a dentist in , as well as that had to remove one of Petitioners teeth from home. stated filed a Grievance and received a Grievance number. stated the denial reason asserts that failed to go through the Appeal process as required, but that did go through the Grievance process.

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

a. On April 8, 2024, requested a plan change from Liberty to MCNA. stated needed to change plans because Liberty does not have providers for enrollees over the age of eighteen. stated filed a Grievance. requested the change due to the lack of access to services covered under the contract with AHCA, including lack of access to medically necessary specialty services.

b. On April 12, 2024, the Agency reviewed the request. Liberty provided a copy of the Grievance Acknowledgement letter dated March 29, 2024, for a Grievance filed on March 28, 2024. No Grievance Resolution was provided by the plan. The request was denied because the enrollee failed to go through the managed care plan's Grievance process as required.

c. On April 15, 2024, the For Cause denial letter was sent to . On April 19, 2024, requested a Fair Hearing. At the time the Fair Hearing was requested, the process was not complete and the plan had not had the full amount of time to provide a written response.

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 this case, the required Grievance process was not completed to Resolution prior to the disenrollment request of the Agency, as required by statute. *See* supra ¶¶ 2, 4. Liberty issued a Grievance Acknowledgement notice on March 29, 2024, stating that Petitioner's Grievance would be resolved in thirty days. *See* supra ¶ 2. Petitioner submitted the For Cause disenrollment request to the Agency on April 8, 2024, prior to the plan's Resolution of ███ Grievance. *See* supra ¶ 3.

Furthermore, no Resolution was provided by the plan upon the Agency's review of the request. *See* supra ¶ 4. As such, Petitioner did not "first [seek] resolution through the managed care plan's grievance process", as required by 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). Here, Petitioner bears the burden of proof, *supra* ¶ 11, and did not submit any evidence of an immediate risk of permanent damage to the enrollee's health. Petitioner also did not submit any evidence of a lack of access to services under the current plan. At the hearing, the undersigned asked if [redacted] had any documents [redacted] would like to submit as evidence, and [redacted] responded that [redacted] did not. 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 10th day of July, 2024, in Tallahassee, Leon County, Florida.

Alani Day
24-FH1272
2024.07.10 09:37:19 -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