



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

FILED

Jul 10, 2024, 12:04 pm

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 24-FH1358

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 11, 2024, at 8:58 a.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.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a ten (10)-page evidence packet. The ten (10)-page evidence packet appears in the Office of Fair Hearings’ document management system as file title “24-FH1358 FC Evidence 10 Pages.pdf”. Absent an objection from Petitioner, the undersigned admitted the ten (10)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of DentaQuest of Florida. (“DentaQuest”). See page 1 of RCE 1. DentaQuest is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. On January 18, 2024, [REDACTED] requested to change Petitioner’s Medicaid plan from DentaQuest to another dental plan. *Id.* at 1. [REDACTED] stated [REDACTED] had not filed a Grievance with the plan. *Id.* [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.*
3. On January 18, 2024, the request was auto denied by the Agency’s system for failure to go through the managed care plan’s Grievance process as required. *Id.*
4. On January 19, 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.

5. On April 25, 2024, [REDACTED] requested a Fair Hearing regarding the denial of a For Cause disenrollment request. *Id.* at 1. On May 15, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, scheduling the hearing for June 11, 2024, at 9:00 a.m. EST.

6. On May 17, 2024, Respondent sent to the Office of Fair Hearings a ten (10)-page evidence packet. The evidence packet reads as follows in pertinent part:

1/18/2024

For Cause Request ID

[REDACTED]

Has the member filed a grievance with the plan?

No

...

Page 9 of RCE 1.

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

- a. [REDACTED] stated Petitioner was denied two medically necessary services. [REDACTED] [REDACTED] stated [REDACTED] appeal was denied, and that [REDACTED] was told to file a Grievance to change plans. [REDACTED] stated Petitioner was seen by an oral surgeon because [REDACTED] has severely impacted wisdom teeth or molars. [REDACTED] stated two of the four

teeth were approved, but that DentaQuest did not deem it medically necessary to remove all four. [REDACTED] stated Petitioner is [REDACTED]

[REDACTED]

b. [REDACTED] stated Petitioner was referred to an orthodontist and [REDACTED]. [REDACTED]

[REDACTED] stated the provider wanted to give Petitioner braces, but that Petitioner may need jaw surgery. [REDACTED] stated the oral surgeon advised a plan change.

c. [REDACTED] stated [REDACTED] filed Grievances with DentaQuest regarding the oral surgeon and the orthodontist. [REDACTED] stated [REDACTED] then called for a plan change and was told to call DentaQuest to obtain a paper document. [REDACTED] stated DentaQuest told [REDACTED] there was no paper document for the Grievance. [REDACTED] stated [REDACTED] had not received any documents from DentaQuest stating that a Grievance had been filed.

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

- a. On January 18, 2024, [REDACTED] requested a plan change from DentaQuest to another dental plan, stating that Petitioner was denied oral surgery. During this call, [REDACTED] stated [REDACTED] had not filed a Grievance with the plan. [REDACTED] requested the change due to the 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 request was auto denied by the System because the enrollee failed to go through the managed care plan's Grievance process as required.
- b. On January 19, 2024, the For Cause denial letter was sent to [REDACTED].

c. On April 25, 2024, [REDACTED] requested a Fair Hearing.

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, there is no evidence that the required Grievance process was complete at the time of the For Cause disenrollment request, as required by statute. [REDACTED] stated [REDACTED] had not filed a Grievance at the time of [REDACTED] For Cause disenrollment request. See supra ¶ 6. While [REDACTED] testified to having filed appeals and Grievances with DentaQuest, [REDACTED] also stated that DentaQuest did not send [REDACTED] documentation that a Grievance was filed. See supra ¶ 7. Petitioner bears the burden of proof in this case and did not submit any documentation, such as a Grievance Acknowledgement or Resolution letter, to demonstrate the start or completion of the required Grievance process. 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). While [REDACTED] testified to Petitioner’s dental issues, Petitioner bears the burden of proof and did not submit evidence beyond [REDACTED] testimony to support [REDACTED] claims. As such, Petitioner has not demonstrated an immediate risk of permanent damage to the enrollee’s health. 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-FH1358
2024.07.10 09:40:03 -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**