STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 14F-02319

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 15, 2014, at 9:15 a.m., with all parties appearing telephonically.

APPEARANCES

For the Petitioner: [redacted], from Assisted Living Facility.

For the Respondent: Dianna Chirino, senior program specialist, Agency For Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action of March 18, 2014 to cancel the petitioner's enrollment in the Long Term Care Program, based on the petitioner not meeting the eligibility requirements of the Program and based on the Agency approving the Long Term Care Program for the petitioner in error. The Agency has the burden of proof.

PRELIMINARY STATEMENT

The petitioner was present. Present as a witness for the Agency was Paula James, bureau chief, Department of Elder Affairs.

Present as observers were [redacted]

Eduardo Robinson was present as an interpreter, though his services were not required during the hearing.

A continuance was granted on behalf of both parties for a hearing scheduled on April 24, 2014.

FINDINGS OF FACT

1. The petitioner currently lives in an ALF (Assisted Living Facility). During early 2013, the petitioner was temporarily admitted to a nursing home. She was discharged from this nursing home in April 2013. At that time when the petitioner was in the nursing home, she met the CARES criteria for short term nursing stay. The Department of Children and Families failed to close the petitioner's ICP (Institutional Care Program) benefits when the petitioner was discharged from the nursing home. The petitioner was also on the "wait list" for the "diversion" related Adult Waiver Program up until November 2013.

2. The petitioner received an approval of the new Statewide Managed Care (SMMC) Long-term care program starting December 2013.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; rules and regulations governing the

contract. The Department of Elder Affairs is responsible for determining clinical eligibility for long-term care services; managing any program waiting list; monitoring – term care plan performance; and assisting enrollees and their families to address complaints with the long-term care plans.

4. The petitioner was sent a denial/termination letter from AHCA dated March 18, 2014, advising: "...you are currently not eligible for the Statewide Medicaid Managed Long-term care program and were enrolled in error." This letter submitted as part of Respondent Composite Exhibit 1, is a "generic" letter that was sent to other individuals with a similar situation as the petitioner and applies to the petitioner.

5. The respondent witness indicated that based on the petitioner being placed, if only temporarily in the nursing home, and based on DCF failing to "close" the petitioner's ICP; the petitioner was placed in the Statewide Managed Care (SMMC) Long-term care program starting December 2013 in error. She indicated that as of the date of the hearing the petitioner is not eligible for this program as the petitioner is not residing in a nursing home or has been released from the Medicaid Waiver Program wait list.

6. The Respondent witness indicated that; however, since the petitioner is a viable candidate to be enrolled is the Long-term care program based on her previous admittance into a nursing home; the CARES unit will complete a review of the petitioner's current situation and if the petitioner meets the CARES criteria, will be reinstated to the Long-term care program.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

9. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the respondent.

10. Fla. Stat. ch. 409.979 sets forth eligibility for the Long-term care program and states:

> (1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
>
> (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
>
> (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).
>
> (2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):
>
> (a) The Assisted Living for the Frail Elderly Waiver.
>
> (b) The Aged and Disabled Adult Waiver.

(c) The Consumer-Directed Care Plus Program as described in s. 409.221.

(d) The Program of All-inclusive Care for the Elderly.

(e) The long-term care community-based diversion pilot project as described in s. 430.705.

(f) The Channeling Services Waiver for Frail Elders.

(3) The Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before enrollment offers, the department shall determine that sufficient funds exist to support additional enrollment into plans.

11. As shown in the Findings of Fact, on March 18, 2014 the Agency notified the petitioner: "...you are currently not eligible for the Statewide Medicaid Managed Long-term care program and were enrolled in error."

12. The petitioner's representative argued that even though she is aware that the Agency apparently enrolled the petitioner in the Lon-term care program in error, the petitioner should be receiving this program anyway. She argued that the petitioner would meet the level of care criteria for the program based on the petitioners' serious medical conditions.

13. The respondent witness argued that based on the petitioner being placed in a nursing home and based on DCF failing to "close" the petitioner's ICP; the petitioner was placed in the Statewide Managed Care (SMMC) Long-term care program starting December 2013 in error. She argued that the petitioner is currently not eligible for this program as the petitioner is not residing in a nursing home or has been released from the Medicaid Waiver Program wait list. She also indicated that the CARES unit will

complete a review of the petitioner's current situation and if the petitioner meets the CARES criteria, will be reinstated to the Long-term care program.

14. For the case at hand, as the petitioner currently does not reside in a nursing home or has been released from a Medicaid Waiver Program wait list; the hearing officer agrees with the Agency decision that the petitioner does not meet the eligibility requirements to be enrolled in the Long-term care program.

15. After considering the evidence, the Fla. Stat. and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the Agency action to cancel/deny the petitioner's enrollment in the Statewide Medicaid Managed Long-term care program, based on: "...you are currently not eligible for the Statewide Medicaid Managed Long-term care program and were enrolled in error.", is correct. The respondent has met its burden of proof. It should be noted that it is the obligation of the Agency; by rule, to complete an exparte determination of Medicaid benefits when any Medicaid benefit is cancelled/terminated. The Agency has agreed as noted above, to complete a review of the petitioner's level of care through the CARES unit for this case in order to explore possible eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 10th day of July, 2014,

in Tallahassee, Florida.

Robert Akel

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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager