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

APPEAL NO.09F-03489

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 1, 2009, at 11:10 a.m., in Daytona Beach, Florida. The petitioner was present. The petitioner was represented by her daughter and her daughter's fiancé, . The respondent was represented by Michelle Manor, Agency for Health Care (AHCA) program administrator. Present telephonically as a witness for the respondent were Jill Hricz, AHCA senior human service program specialist and Robert Schemel, president of American Eldercare. Joy Styrcula, contract manager with the Department of Elder Affairs was present as an observer.

The record was held open for 14 days, until October 15, 2009, for the submission of additional evidence. The deadline was subsequently extended until November 2,

2009; the evidence was received on October 30, 2009 and entered as Respondent's Composite Exhibit 4.

ISSUE

The petitioner is appealing the respondent's decision to deny retroactive disenrollment from the Medicaid Waiver Long Term Care Diversion Program (LTCDP) for the month January 2009 and the respondent's decision to deny payment of the petitioner's January 2009 Institutional Care expenses.

FINDINGS OF FACT

1. During the time of the action under appeal, the petitioner was enrolled in the Medicaid Waiver LTCDP; the petitioner had been receiving services under this program since August 2008. The purpose of Medicaid LTCDP is to avoid or delay unnecessary and costly nursing home placement and enhance quality of life by providing alternative, less restrictive long-term care options for seniors who qualify for Medicaid. These options include care in the home, or in a community setting such as an assisted living facility or adult day care center. American Eldercare is a company contracted by AHCA to provide LTCDP waiver services; the petitioner received her waiver services through this company.

2. The LTCDP waiver adult day care services were being provided (in conjunction with care from the petitioner's family) in the home of the petitioner's daughter with whom she was living. Sometime in late 2008, the petitioner's daughter injured her arm and was no longer able to assist with the petitioner's care; she contacted American Eldercare for increased adult day care (in the home). In December 2008, the petitioner's daughter contacted American Eldercare regarding

what she believed to be unsatisfactory adult day care services; she asserted that the care providers either came late or did not come at all which required that she (with an injured arm) try to provide the petitioner's care. The petitioner's daughter requested that the petitioner be placed in a nursing home. She believed that she could no longer meet the petitioner's needs in her home. American Eldercare assessed the situation and determined that the petitioner only needed assistance with the activities of daily living (bathing, dressing, etc.) and therefore she did not qualify for institutional care (nursing home) services; it was determined that her needs could be met in an assisted living facility (ALF). American Eldercare provided a list of participating ALFs' for the family's review.

3. The petitioner's daughter asserted that she visited several of the ALFs provided by American Eldercare without success; it was determined (via conversations with ALF staff members) that the petitioner's needs could not be met at an ALF because she can not stand on her own, she requires two people to assist with lifting and standing.

4. The petitioner's daughter, independent of American Eldercare, placed the petitioner in a nursing home ; the facility is not a provider covered by the LTCDP waiver) on January 2, 2009. During the hearing, the petitioner's daughter explained that her mother has Medicare Part A coverage which the family believed would cover the petitioner's first month in the nursing home (January 2009). The family was in the process of terminating the LTDCP waiver services during the month of January 2009 and then planned to apply for Institutional Care Program (ICP) Medicaid with the Department of Children and Families (DCF); the family expected Medicaid to

cover the nursing home charges effective February 2009 (and ongoing). However, Medicare did not pay for the petitioner's January 2009 nursing home charges because it was determined that she did not require skilled nursing care (Medicare only pays for skilled nursing services). It was determined that petitioner required intermediate custodial care; Medicare does not pay for custodial care. The family applied for ICP Medicaid retroactively to January 2009; DCF approved the ICP Medicaid application effective January 2009, however, AHCA denied payment (twice) of the nursing home charges for the month of January 2009 because the petitioner was still enrolled in the LTCDP waiver (recipients can not receive both services at the same time). The petitioner's daughter (via a loan from another family member) paid privately for the January 2009 nursing home charges; approximately $7400. The family believes Medicaid should have paid for the charges and would like reimbursement. The American Eldercare/LTCDP Acknowledgment of Program Purpose Agreement signed by the petitioner's daughter on August 27, 2008 states in part:

> I understand that the goal of the Long-Term Care Diversion Program is to provide needed services in order to delay or avoid nursing home placement. It is my responsibility to work along with my care manager to develop a plan of care, which will allow me to remain safely in the least restrictive environment, based on my acute and custodial care needs.
>
> I further acknowledge that I am not eligible to choose to move into a nursing home for custodial care without the consent of American Eldercare, nor a provider that refuses to work within their network. In the event that I choose to move into a nursing home, when I can be cared for in a less restrictive environment or outside the provider network, I realize that I will need to go through disenrollment process and I will incur all costs to the nursing home.
>
> I have been informed that I am not eligible for the ICP Medicaid Program while enrolled in the Long-Term Diversion Program, and will be exempt

from receiving any retroactive payments that the ICP Program would normally allow.

5. The petitioner's disenrollment from the LTDCP waiver was completed effective February 1, 2009; her February 2009 nursing home charges and the nursing home charges for all subsequent months have been paid by ICP Medicaid (excluding the petitioner's patient responsibility). American Eldercare explained that the disenrollment request was received from the petitioner's daughter on January 5, 2009 and therefore, February 2009 was the first month disenrollment was possible. The petitioner's daughter asserted that she initially requested the disenrollment on December 15, 2008; she received no response from American Eldercare and submitted a second disenrollment request on January 5, 2009. Both requests were faxed to American Eldercare, per the petitioner's daughter; she did not have transmission confirmation receipts. However, based on the family's assertions that a request was made in December 2008, AHCA agreed to reconsider retroactive disenrollment (from the LTCDP waiver) effective January 1, 2009. AHCA explained that if successful, the retroactive disenrollment would allow the nursing facility to bill Medicaid again for the petitioner's January 2009 expenses and accordingly (if the two parties could reach an agreement) the facility would be in a position to refund the monies received from the family. AHCA made it clear that its policies would not allow the agency to reimburse the recipient or the recipient's family directly for monies paid to the facility. On October 30, 2009, the undersigned received an electronic communication from AHCA which states in part: "The file of Ms. [redacted] *[sic]* (Appeal # 09F-03489) has now been updated to reflect Medicaid (not Nursing Home Diversion Plan) for the month of January 2009."

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. ch. 120.80.

Fla. Stat 409.903 Mandatory Payments for Eligible Persons states in part:

> The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216...

The above cited legal authority explains the Medicaid will make payments to providers on behalf of recipients who meet all the requirements of eligibility.

The Florida Medicaid Provider General Handbook, Payment for services, states in part:

> Medicaid provides an eligible recipient with access to Medicaid services by direct payment to the Medicaid provider upon submission of a payable claim to the Medicaid fiscal agent. Payments for Medicaid services must be made by direct payment to the provider, except in the following circumstances:
>
> Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by court order.
>
> Payment may be made in the name of the provider to the provider's Medicaid-enrolled billing agent's address...
>
> Pay-to-provider is a term used in the Medicaid program to refer to the enrolled Medicaid provider who receives payment from Medicaid for

> covered services provided to eligible recipients. The pay-to-provider can be the provider who has provided treatment to a Medicaid recipient or the provider group to which the treating provider belongs.

The Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook states in part:

> Medicaid reimburses nursing facilities for services provided to residents who have been determined to meet Medicaid ICP eligibility. In all cases, in order to receive reimbursement from Medicaid for nursing facility care, the facility must have received written notification from the Department of Children and Families approving the individuals for institutional care benefits.

The above Florida Medicaid Handbooks explain that Medicaid pays the providers that provide medical services to recipients who are eligible for Medicaid.

The State Medicaid Manual is used by the Centers for Medicare and Medicaid (CMS) to issue Medicaid policies and procedures to the Medicaid State agencies. At Section 6320, "Direct Reimbursement by States to Medicaid Recipients to Correct Erroneous Denials", it states in relevant part:

> 6320.1 Background.--Some individuals, while appealing an initial denial of eligibility, incur and pay for covered Medicaid services. Subsequently, upon receipt of a favorable decision, the individuals request direct reimbursement from the State for services that would have been paid by Medicaid had the initial determination been correct. The policy of direct reimbursement to recipients is an exception to the vendor payment principle in §1905(a) of the Act, which prohibits payments to recipients except in specific circumstances set forth in §1905(a) and in 42 CFR 447.25(d)(1). It was adopted in response to litigation on behalf of individuals who paid for covered medical services pending a reversal of an unfavorable determination. Section 1905(a) authorizes direct payment to recipients for certain physicians' services and dentists' services. 6320.2 Payment for Services.--States may make direct reimbursement to individuals who paid for covered services after an erroneous determination of ineligibility which is reversed on appeal. The purpose of this exception to the vendor payment principle is to correct the inequitable situation that

results from an erroneous determination made by the agency. 6320.3 Requirements To Be Met Before Direct Reimbursement To Individuals Is Permitted.--FFP is available in State payments to individuals for direct reimbursement for corrective payment only if the following requirements are met:

- The services were paid for during the period between a denial of eligibility and a successful appeal of that denial and the services were covered under the State plan at the time the services were provided.
- Third party reimbursement is not available for the services.
- Proof those payments were made by the applicant or a person legally responsible for the applicant's bills must be submitted. Direct payments must be supported by the provider's bills for services.
- Vendor payments would otherwise have been appropriate except that the provider does not have to be participating.
- Services must have been medically necessary when provided. However, because of your erroneous eligibility determination, the recipient was not subject to prior approval. Do no apply any prior approval requirements to such services.
- Payment is made at the level of your fee schedule or the upper limit as specified in the State plan for the services in question, which was in effect at the time the service was provided, even though the individual may have paid more than that amount.

The above authority explains that Medicaid recipients may be eligible for direct reimbursement of medical cost for treatment that occurs after an erroneous termination and prior to the reinstatement of benefits.

Medicaid Regulations at 42 C.F.R 431.200, General Provisions, states in relevant part:

This subpart--

(a) Implements section 1902(a)(3) of the Act, **which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;**

(b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and

(c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who--

(1) Is subject to a proposed transfer or discharge from a nursing facility; or

(2) Is adversely affected by the pre-admission screening or the annual resident review that are required by section 1919(e)(7) of the Act.

The legal authority cited above explains that an opportunity for a fair hearing is provided when a claim for assistance has been denied or not acted upon promptly.

The Florida Medicaid Summary of Services Handbook states in part:

Waiver – Aged/Disabled Adult

Background

The Aged/Disabled Adult (A/DA) Waiver is a home and community based services (HCBS) program that was implemented in April 1982. The Florida Department of Elder Affairs (DOEA) operates the waiver for frail individuals 60 years old and older and the Florida Department of Children and Families' (DCF) Adult Services program operates the waiver for individuals with disabilities 18 to 59 years old. The Agency for Health Care Administration operates the cognitively intact, medically complex, and technologically dependent "Aging Out" portion of the waiver for individuals age 21 or older who have previously been served through Children's Medical Services.

Description

The waiver includes the following services: adult companion, adult day health care, attendant care, caregiver training, case aide, case management, chore , consumable medical supplies, counseling, emergency alert response systems, escort, financial assessment/risk reduction, home-delivered meals, home modifications, homemaker, nutritional risk reduction, occupational therapy, personal care, pest control, physical risk reduction, physical therapy, rehabilitation engineering, respiratory therapy, respite, skilled nursing, specialized medical equipment, and speech therapy. Beneficiaries make an informed choice of receiving HCBS instead of nursing facility care.

Eligibility

To be eligible for the A/DA Waiver services, an individual must meet the following criteria:

- Be 60 years old or older or be ages 18 to 59 and determined disabled according to Social Security standards;
- Be Medicaid eligible; and
- Meet nursing facility level-of-care criteria as determined by Comprehensive Assessment and Review for Long-Term Care Services (CARES).

Reimbursement
Authorized services provided to enrolled waiver beneficiaries are provided on a fee-for-service basis. Medicaid reimbursement for services is the Medicaid fee or the provider's customary fee, whichever is lower.

The above passages from the Medicaid Services Handbook explains the eligibility and reimbursement rules of the Aged/ Disabled Adult Waiver Program.

For the time period under issue (January 2009), the petitioner was enrolled in a Long Term Care (nursing home) Diversion Medicaid Waiver Program. The Program is designed to provide recipients with needed medical services in a community setting; therefore delaying nursing home placement. In early 2009, the petitioner was admitted into a nursing facility that does not participate in the Long Term Care Diversion Medicaid Waiver Program. The legal authorities explain that services received from a non-authorized provider will not be paid by the waiver program. The petitioner subsequently applied and was approved for ICP Medicaid by DCF for the month of January 2009; however, AHCA denied payment of the petitioner's nursing home charges under that program for the month of January 2009 due to her continued enrollment in the waiver program. The family paid privately for the petitioner's January 2009 nursing home charges; they are seeking reimbursement by Medicaid. The agency's policies explain that direct recipient reimbursement is only applicable when an application for Medical assistance has been erroneously denied. This is not the situation in the instant case and therefore, the recipient is not eligible for direct reimbursement by Medicaid. However, subsequent to the hearing, the respondent retroactively disenrolled the petitioner from the waiver Program effective January 1,

2009 and opened ICP Medicaid coverage effective January 1, 2009 in the Florida Medicaid system. As a result, the nursing facility can now bill ICP Medicaid for the petitioner's January 2009 charges and subsequently reimburse the petitioner for the private payment made for that month.

DECISION

The retroactive disenrollment issue is hereby dismissed as moot as subsequent to the hearing, the agency accomplished the disenrollment for January 2009. The appeal for direct reimbursement for payment of the petitioner's January 2009 nursing home charges is denied as explained in the above conclusion.

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 Agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 18th day of November, 2009,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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