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

APPEAL NO.09F-07772

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically before the undersigned hearing officer on January 11, 2010, at 1:38 p.m. The petitioner was not present; she was represented by her son The respondent was represented Jill Hricz, AHCA senior human service program specialist. Robert Schemel, compliance officer with American Eldercare was present as a witness for the respondent.

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 February 2009 and the respondent's decision to deny payment of the petitioner's February 2009 nursing home charges under Institutional Care Program

(ICP) Medicaid. The petitioner was receiving LTCDP and was terminated beginning February 2, 2009.

FINDINGS OF FACT

1. The petitioner was enrolled in the Medicaid Waiver LTCDP from approximately March 2007 through February 2009. 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 (ALF) or adult day care center. American Eldercare is a company contracted by Department of Elderly Affairs to provide the petitioner's LTCDP waiver services.

2. The petitioner was transferred from an ALF to a nursing home in May 2008 to undergo rehabilitation therapy (due to weakness and dehydration). In January 2009, American Eldercare determined that the petitioner no longer needed rehabilitation therapy and should be transferred from the nursing facility to an ALF. American Eldercare informed the petitioner's son of this decision and advised that she would need to move into an ALF as soon as possible. The petitioner's son indicated he might want to disenroll the petitioner and seek Institutional Care Program Medicaid coverage for nursing home care to continue. American Eldercare informed the son that since it was already January 28, 2009, a disenrollment now would be effective February 28, 2009 and he would be responsible for the nursing home charges for February 2009 if he decided to remove her from the program. The son asked for an extension of time to make his decision. American Eldercare extended its coverage for the petitioner through

February 2, 2009. On February 2, 2009, the son advised American Eldercare that he had decided to disenroll his mother from the LTCDP and seek ICP eligibility so she can remain in the nursing home. The disenrollment form was sent to the son on February 2, 2009 and returned on February 4, 2009.[1] American Eldercare submitted forms to DCF on February 6, 2009 to show the disenrollment effective February 28, 2009.

3. The petitioner was subsequently approved for ICP Medicaid effective retroactively to February 1, 2009; however, the respondent denied Medicaid payment of the nursing home charges for the month of February 2009 because the petitioner was still enrolled in the LTCDP that month (Medicaid recipients can not participate in both programs during the same month). Medicaid has paid the petitioner's nursing home charges (minus any applicable patient responsibility) effective March 2009 and ongoing.

4. The petitioner's son requested that American Eldercare reconsider retroactively disenrolling her from the LTCDP effective February 1, 2009 or pay her February 2009 nursing home charges ($4500). On October 14, 2009 the respondent denied request. The letter denial letter states in part:

> The appeals committee met and reviewed your request for additional custodial coverage for your mother...for the dates of service 2/2/09 – 2/28/09. The appeals committee has denied the appeal. Ms. Dix no longer met the criteria for authorization for custodial placement in a nursing home. Her needs could have been met in a less restrictive environment such as an assisted living facility. Your request for disenrollment was not received until 2/9/09. The cut off date for January 31, 2009 disenrollment was 1/21/09.

5. The petitioner's son requested a hearing on November 6, 2009. It is his position that she requires 24/7 skilled nursing care. He explained that his mother

[1] It is noted that testimony said February 4, 2009 and the grievance notice says February 9, 2009.

suffers from dementia, she is a fall risk, she is incontinent of bowel and bladder, she suffers from hypertension, depression, osteoporosis and severe back pain, and she needs assistance showering, dressing and grooming.

6. The respondent was aware of the petitioner's impairments. It was determined, via an assessment by American Eldercare, that an ALF with extended services (an ALF that is staffed and equipped to take care of the petitioner's incontinence, falls, etc.) could meet her needs. The respondent concluded that the petitioner did not require custodial care after February 2, 2009. The American Eldercare/LTCDP Acknowledgment of Program Purpose Agreement signed by the petitioner's son on March 19, 2007 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.

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.

Florida Administrative Code 65-2.060, Evidence, state in part:

> (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

The above authority explains that the burden of proof in an administrative hearing is on the Agency when action is taken to terminate benefits received by the recipient. In this case, the issue was presented to the undersigned of a denial of payment for February 2009. However, upon further review, the undersigned concludes that the burden of proof is the Agency's in this case as the petitioner was receiving Medicaid Waiver under American Eldercare until February 2, 2009 when the nursing facility payment was terminated, although the petitioner remained enrolled with American Eldercare for Medicaid services through the month of February 2009.

Federal Regulations at 42 C.F.R. §431.206, Informing applicants and recipients, states in relevant part:

> (a) The agency must issue and publicize its hearing procedures.
> (b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or recipient in writing--
> (1) Of his right to a hearing;
> (2) Of the method by which he may obtain a hearing; and
> (3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.
> (c) The agency must provide the information required in paragraph

(b) of this section--(1) At the time that the individual applies for Medicaid;
(2) At the time of any action affecting his or her claim; ...

Federal Regulations at 42 C.F.R. §431.210 Fair Hearings for Applicants and Recipients, Content of notice states:

A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
(b) The reasons for the intended action;
(c) The specific regulations that support, or the change in Federal or State law that requires, the action;
(d) An explanation of--
(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Federal Regulations at 42 C.F.R. §431.211, Advance Notice, Fair Hearings for Applicants and Recipients, states:

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under Sec. Sec. 431.213 and 431.214 of this subpart.

Federal Regulations at 42 C.F.R. §431.230, Maintaining services, states:

(a) If the agency mails the 10-day or 5-day notice as required under Sec. 431.211 or Sec. 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless--
(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision...

The above authorities reference the notice requirements for state plan Medicaid and inform that 10 day advance notice must be given before the date of action. If timely appealed, the agency may not terminate or reduce services until a decision is rendered by the hearing officer.

Federal Regulations at 42 C.F.R. §438.404, Notice of action states in part:

> (a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
>
> (b) Content of notice. The notice must explain the following:
>
> (1) The action the MCO or PIHP or its contractor has taken or intends to take.
>
> (2) The reasons for the action.
>
> (3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
>
> (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
>
> (5) The procedures for exercising the rights specified in this paragraph.
>
> (6) The circumstances under which expedited resolution is available and how to request it.
>
> (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
>
> (c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:
>
> (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Sec. Sec. 431.211, 431.213, and 431.214 of this chapter.
>
> (2) For denial of payment, at the time of any action affecting the claim.
>
> (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1).
>
> (4) If the MCO or PIHP extends the timeframe in accordance with Sec. 438.210(d)(1), it must--
>
> (i) Give the enrollee written notice of the reason for the decision

to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).

42 C.F.R. §438.408, Resolution and notification: Grievances and appeals, states in part:

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees--

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; ...

42 C.F.R. 438.420, Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending, states in part:

(a) Terminology. As used in this section, ``timely" filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if--

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The enrollee requests extension of benefits.

(c) Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
(1) The enrollee withdraws the appeal.
(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.
(4) The time period or service limits of a previously authorized service has been met.
(d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in Sec. 431.230(b) of this chapter.

The above authorities address the notice requirements for a Medicaid HMO and mirror the state plan Medicaid requirements. It is recognized that American Eldercare is an HMO or Managed Care Organization contracted by the respondent to manage the individual's care under the LTCDP Medicaid Waiver Program.

The Findings show that the petitioner was enrolled in the LTCDP through February 2, 2009. However, no findings could be made as to when the agency notified the petitioner (or son) in writing that she was disenrolled or when the agency notified the petitioner that it was no longer paying for the nursing home charges for February 2 through February 28, 2009. It is unclear from the record if the above Medicaid federal requirements were met due to the original notice not being presented at the hearing; the

undersigned cannot determine if an advance written notice was issued prior to the decision not to pay for nursing home care for February 2009.

While the respondent indicated it relied on Florida Statute 430.705, Florida Administrative Code 59G-1.010 (166)(a) and the General Provider Handbook to make the decision not to cover the nursing home charges for February 2009, the undersigned concludes these authorities are general in nature and do not support the termination of payment for the petitioner's nursing home care for February 2009 when she was enrolled through February 28, 2009. The above Medicaid and Medicaid HMO authorities require advance notice to be given before terminating a service. Without the original notice and without any alternative legal authorities, the undersigned concludes the agency did not meet its burden to show that the advance notice was issued with hearing rights, prior to the termination of coverage for February 2009. Disenrollment did not happen until February 28, 2009 and American Eldercare was paid a capitated amount for the petitioner's care for that month. Therefore, American Eldercare is hereby ordered to pay for the nursing home charges for February 2009.

DECISION

The appeal is granted. American Eldercare is ordered to pay for the nursing home care for the entire month of February 2009.

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 4th day of February, 2010,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: