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

[redacted]

PETITIONER,

APPEAL NO. 15F-07806

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 9, 2015 at 1:11 p.m.

APPEARANCES

For the Petitioner: [redacted] daughter

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether respondent's action reducing the home health care hours the petitioner receives through Medicaid was correct. The respondent holds the burden of proof in this matter.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid Program. The respondent contracts with healthcare maintenance organizations (HMOs) to provide medical services to its program participants. Sunshine Health (Sunshine) is the contracted HMO in the instant case.

By notice dated August 28, 2015, Sunshine informed the petitioner that the home health care hours he receives through Medicaid were being reduced from 32 hours of Personal Care weekly to 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services weekly (15 hours).

The petitioner requested reconsideration.

By notice dated September 30, 2015, Sunshine informed the petitioner that the decision had been partially overturned. The home health care hours were being reduced from 32 hours of Personal Care weekly to 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker care weekly (26 hours total).

The petitioner timely requested a hearing to challenge the reduction decision. The home health care hours have been continued at the previous level pending the outcome of the hearing.

There were no additional witnesses for the petitioner. His home health aide, [redacted] called in for the hearing, but had to leave due to a scheduling conflict before she was called to testify. Petitioner's Composite Exhibits 1 and 2 were admitted into the record.

Representing Sunshine were Dr. John Carter, long term care medical director; Paula Daley, appeals and grievance coordinator; Natalie Grissett, long term care supervisor; Felicia Young, long term care case manager; and Tammi Swan, long term care director. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on November 12, 2015 for the submission of additional evidence. Evidence was received from the petitioner and admitted as Petitioner's Composite Exhibit 3.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 63) is a Florida Medicaid recipient. He is enrolled with Sunshine HMO.

2. The petitioner's suffers from [redacted] and a history of [redacted] The petitioner is technically verbal, he can express when he in hungry, but lacks the cognitive ability to engage in a conversation or respond to questions. The petitioner can walk short distances only, he usually transports by wheelchair. The petitioner feeds and takes medications by mouth. The petitioner is incontinent of bowel and bladder. The petitioner requires total assistance with all activities of daily living (ADLs).

3. The petitioner lives in the family home with his daughter, the daughter's husband and their two minor children (ages 16 and 12). The daughter was the petitioner's primary caregiver. She does not work outside the home. She underwent

back surgery recently. She is no longer able to assist with the petitioner's care, except light ADLs. Both children suffer from developmental delay and require a lot of care. The husband is a long distance truck driver. He works six days a week, 14 hours a day. He does not assist with the petitioner's care.

4. Prior to the action under appeal, the petitioner was enrolled in Sunshine's Managed Care Plan. He received 28 hours of Personal Care weekly under the Managed Care Plan. His daughter provided the remainder of his care.

5. The daughter reached out to the Eldercare Resource Center to inquire about receiving additional Personal Care hours. Caring for the petitioner and her family was depleting her personal and financial resources. She was advised to enroll in a program which specializes in long term care home health services. She was advised that the petitioner could receive additional support services in a specialized program

6. The daughter applied for participation in Sunshine's Long Term Care Program (LTCP) in late 2014. LTCP provides home health services to individuals who would otherwise require nursing home placement. The level of service provided by Medicaid is based on recipient's medical condition, support needs, and natural supports. Enrollment slots in the LTCP are limited. The petitioner was wait listed for approximately a year. During this time, he continued to participate in Sunshine's Managed Care Plan and receive 28 hours of Personal Care weekly.

7. In August 2015, the petitioner was approved for participation in Sunshine's LTCP. LTCP staff reached out to the petitioner to determine the level of home health service he needed. The daughter was scheduled for back surgery during this time

which would prevent her from being able to assist with the petitioner's care, particularly heavy ADLs (changing incontinence pads, bathing, dressing, etc.). The two parties settled on 39 hours of home health services weekly: 32 hours of Personal Care, 4 hours of Respite, and 3 hours of Homemaker Care. Because of his age (63), the petitioner was allowed to remain enrolled in the Managed Care Program as well. He receives all non-LTCP services through the Managed Care Program.

8. Sunshine LTCP approved the 39 hours of care weekly for approximately 30 days and then reduced the weekly home health hours to 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services,15 total hours weekly of home health services. The petitioner's daughter requested reconsideration. Sunshine partially reversed its decision; it authorized 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker Care weekly, 26 total hours weekly of home health services.

9. Sunshine based its decision on a review of the petitioner's status assessment, called a 701B assessment, Plan of Care, and available clinical records.

10. The 701B assessment is a snapshot of the petitioner's functional, behavioral, and physical status. The 701B assessment is completed quarterly by the member's case manager. The manager interviews the member (when possible), family, and caregivers. The petitioner's 701B assessment was completed on August 4, 2015. The assessment concluded that the petitioner required moderate to maximum assistance with all ADLs.

11. The Plan of Care is a narrative developed with the assistance of the member's support team. It outlines the needed services, service goals, and service providers for the upcoming certification period. The petitioner's Plan of Care was completed on August 1, 2015. The Plan of Care concluded that the petitioner's goal was to remain safely in the family home with consumable medical supplies and home health care services.

12. The clinical data reviewed by Sunshine included a prescription from the petitioner's treating physician which generically prescribes continuation of home health care services.

13. The 701B assessment, the Plan of Care, and clinical records were submitted to a Sunshine utilization review team, comprised of nurses and clinicians. The team reviewed the data and determined that the petitioner's service needs could be met with 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services,15 total hours weekly of home health services.

14. The utilization team submitted its recommendation to the LTCP medical director, Dr. John Carter. Dr. Carter made the final decision. He concurred with the recommendation of the utilization review team.

15. The petitioner's daughter requested reconsideration. The reconsideration review was completed by another Sunshine physician, not Dr. Carter. The reviewing physician determined that the petitioner's incontinence needs warranted additional service hours; 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker Care weekly, 26 total hours weekly of home health services.

16. Dr. Carter is board certified in home health care. Dr. Carter appeared as a witness during the hearing. Dr. Carter concurred with the reconsideration decision. Dr. Carter opined that, based on the available data, the petitioner's needs can be met with 26 hours of home health services weekly. Dr. Carter opined that the available date does not support the necessity of additional hours of care.

17. The petitioner's daughter questioned how it was possible for Sunshine's Managed Care Plan, a generic plan, to conclude that more home health hours were necessary, 28 hours weekly versus 26 hours weekly determined by its LTCP, the home health care specialty plan. Sunshine witnesses could not answer the question. The Managed Care Plan and the LTCP are staffed by a different team of people. Each teams works independently. The teams do not consult or communicate when making service decisions.

18. The petitioner's daughter disputed the accuracy of the 701B assessment which concluded that the petitioner requires moderate to maximum assistance with ADLs. The petitioner requires total assistance with all ADLs. Caring for the petitioner is complicated by his mental illness and behaviors. Caregivers must be patient and wait for him to comply with care needs. It takes approximately an hour to bathe and dress the petitioner twice daily. It takes approximately 45 minutes to change the petitioner's diapers two to three times daily between baths. It takes 30 to 45 minutes to feed the petitioner three times daily. He also has multiple snacks daily. He is an aspiration risk and cannot be left alone. The petitioner must be supervised at all times due to his

behaviors. The petitioner cannot attend day programs because he engages in sexually inappropriate behaviors.

19. The daughter had back in surgery in September 2015. She had a rod placed in her back. She will never be able to life more than 20 pounds. The petitioner weighs 130 pounds. The daughter can no longer assist with his ADLs (changing diapers, bathing, dressing, etc.), except light duties, like feeding or grooming.

20. The daughter attends physical therapy three times weekly for an hour. The household circumstances are further complicated by the fact that the daughter's two children suffer from developmental delay. They attend therapy and other activities, which require the daughter to be away from home several hours per week. The petitioner cannot be left home alone.

21. The family currently pays out of pocket for approximately five hours of Personal Care weekly; this is above and beyond the 39 hours of home health services the petitioner receives from LTCP weekly. (The higher service level of 39 hours approved during the daughter's surgery has been continued pending the hearing decision.)

22. The petitioner has lived with the daughter's family since 2012. The family took him in because he failed to thrive in an institutional setting. The family feared for his life.

CONCLUSIONS OF LAW

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

24. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

25. At issue is a reduction in Medicaid services. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the respondent.

26. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

27. The Florida Medicaid Program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid Program is administered by the respondent. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
>
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing

services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services. (c) The agency may not pay for home health services unless the services are medically necessary …

28. The definition of medically necessary is found in the Fla. Admin Code. R 59G-1.010 which states:

(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
. . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

29. The cited authorities explain that home health services must be medically necessary. The level of service provided by Medicaid is based on numerous factors, including recipient's medical condition, support needs and natural supports. The authorities explain further that Medicaid services cannot be provided in excess of a recipient's needs.

30. The respondent approved 39 hours weekly of home health services for the petitioner because his primary caretaker, his daughter, was undergoing back surgery and would not be able to participate in his care. The respondent approved the higher level of care for 30 days only, expecting that the daughter would recover completely be able to resume her previous level of care. The respondent later reduced the petitioner's home health services to 26 hours weekly.

31. The evidence proves that there has been a permanent change in the daughter's medical condition. She has a 20 pound lifting restriction. The petitioner weighs 130 pounds and requires total assistance with all ADLS. The daughter will never be able to resume her role as the petitioner's primary caretaker.

32. The respondent was not aware of the permanent change in the petitioner's level of natural supports when it made the decision under challenge. This hearing is a de novo proceeding which means relevant information not previously known to one or both parties can be taken into consideration.

33. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that respondent did not meet its burden of proof in this matter. The respondent did not prove by a preponderance of the evidence that the petitioner's

home health service needs can be met with 26 hours of care weekly. The evidence proves that the petitioner's current level of home health services, 39 hours weekly, is medically necessary due to loss of natural supports.

DECISION

The appeal is GRANTED.

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 09 day of December, 2015,

in Tallahassee, Florida.

Leslie Green
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