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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-02768

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pinellas
UNIT: AHCA

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 23, 2009, at 3:17 p.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by her daughter, and , director of admissions at

Witness for the petitioner was , registered nurse. The respondent was represented by Marty Ademy, senior human services program specialist, and Robert Schemel, president of American Eldercare. Joy Styrcula, program analyst with the Department of Elder Affairs, was observing.

ISSUE

The petitioner is appealing the respondent's action to deny Long Term Care waiver payment for custodial care for the petitioner in a nursing home for April 2008 and to deny disenrollment effective April 1, 2009.

FINDINGS OF FACT

1. The petitioner applied for the Long Term Care Waiver. The Long Term Care waiver is one of the Home and Community Based Services Waivers. The petitioner met the criteria for skilled care. The petitioner medical condition was cognition decline and stage 1 pressure wound. The Long Term Care Waiver is to program of services to allow an individual to remain in a less restrictive setting than a nursing home such as their home or an assisted living facility. The petitioner was residing in assisted living time of application. The petitioner met the criteria for the Long Term Care Waiver.

2. The petitioner was enrolled in the

Diversion Program. The petitioner signed an Acknowledgement of Program Purpose on August 1, 2008. The petitioner acknowledged as follows. She was not eligible to choose to move into a nursing home for custodial care without the consent of If she chose to move into a nursing home when she could be cared for in a less restrictive environment, she would have to go through the disenrollment process and she would incur all costs to the nursing home. She was not eligible for Institutional Care Program benefits while enrolled in the Long Term Care Diversion Program and would be exempt from receiving any retroactive payments the Institution Care Program would normally allow. The petitioner indicated that she received a copy of the

Plan's Member Handbook/Provider Directory.

3. The Plan's Member Handbook/Provider Directory explained services including the Conditions of Enrollment, Skilled Nursing

Facilities and Voluntary Disenrollment. Under section Skilled Nursing Facilities, the petitioner was informed that to move into an approved and contracted skilled nursing facility for custodial care the petitioner would need have prior approval from her Care Manager with

4. The Diversion Program is as outlined in their Disenrollment Procedure Policy. The disenrollment is effective at 12:00:01 a.m. of the first day of the month after a disenrollment form is received, before the cut off date of the previous month. The cut off date is the Wednesday before the last two Saturdays of the month. If the member submits a disenrollment form after the cut off date, the effective date will be 12:01 a.m. of the first day of the second month following.

5. On March 9, 2009, the petitioner was residing in assisted living. There was no change in the Care Plan as of March 9, 2009. The petitioner medical condition was cognition decline and stage 1 pressure wound, resolved. On March 20, 2009, the petitioner transferred out of assisted living to skilled nursing care. The petitioner did not contact her case manage at prior to moving. As of March 20, 2009, the petitioner had not disenrolled from the Diversion Program.

6. The skilled nursing care facility requested payment for the petitioner for custodial care for April 2008. sent a letter the skilled nursing care facility on March 24, 2009. informed the facility that the petitioner was enrolled in the and was not eligible for nursing home payment without prior authorization.

7. The petitioner requested disenrollment on March 31, 2009. The petitioner requested that the disenrollment be effective April 1, 2009.

sent the skilled nursing facility a letter on April 2, 2009.

notified the skilled nursing facility that would not pay for custodial care as the petitioner as a member of the waiver and the petitioner could have her needs met in a less restrictive environment.

notified the skilled nursing facility that the petitioner's disenrollment would be effective April 30, 2009.

8. The petitioner's representative presented that the petitioner's needs could not be met in assisted living. The only skilled services the petitioner received were physical therapy and occupational therapy. The representative submitted a Physician Certification of Qualifying Condition. The certification was not dated. The diagnosis was general debility. The petitioner's daughter attested that the petitioner was "too needy" and she did not want to move the petitioner to a different assisted living as she wanted her mother and father to be at the same location.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

The Code of Federal Regulations at 42 C.F.R. § 435.712 sets forth the rule for Individuals receiving home and community-based services. The Florida Statutes at Fl. Stat. § 430.705 sets forth the implementation of the long-term care community diversion pilot projects. The Florida Administrative Code at 59G-8.100 "Medicaid Contracts for Prepaid Health Plans" sets forth covered services, enrollment and disenrollment:

> (d) Covered Services. The Medicaid services the contractor agrees to provide under the terms of the contract with the department...
> (f) Disenrollment. The discontinuance of an enrollee's membership in a contractor's prepaid plan...
> (j) Enrollee. An eligible recipient who is a member of a contractor's prepaid plan.
> (k) Enrollment. The process by which an eligible recipient becomes a member of the contractor's prepaid plan...
> (m) Health Maintenance Organization, HMO. An entity certified by the Florida Department of Insurance under applicable provisions of Part II of Chapter 641, F.S...
> (7) Enrollment Requirements.
> (a) Eligibility for enrollment.
> 1. Subject to the terms in the contract between the contractor and the agency, all persons who are eligible to receive Medicaid services and reside in a contractor's service area are eligible to enroll, except as provided in sub-paragraph 2...
> (b) Enrollment shall be in whole months.
> (c) The contractor shall accept the Medicaid eligible recipient for enrollment in the physical and mental condition the recipient is in at the time of application.
> (d) At the time of enrollment, the contractor shall advise the enrollee of all the enrollee's rights and responsibilities as set forth in this rule and the contract between the agency and the contractor...
> (8) Disenrollment Requirements.
> (a) Disenrollment shall be in whole months.
> (b) All enrollees must be advised of the right to file a grievance prior to or upon disenrollment.
> (c) An enrollee's right to disenroll from a prepaid health plan developed under Medicaid shall not be restricted during the term of enrollment.
> (14) Covered Services.

(a) The contractor is not required to provide all the service categories enumerated in the Medicaid State Plan.
(b) The amount, duration and scope of each covered service under the contract may be more but not less than the service requirements under the Medicaid State Plan...
(15) Out of Plan Use...
(b) When an enrollee utilizes covered services, other than emergency services and family planning services, available under a Medicaid-funded prepaid plan from a non-contract provider, the contractor shall not be liable for the cost of such utilization unless the contractor referred the enrollee to the non-contract provider or authorized the out of plan utilization. The enrollee shall be liable for the cost of unauthorized use of contract covered services from non-contract providers...

Florida Administrative Code 59.G-1.010, "Definitions", states for medical necessity:

(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.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(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.

Effective April 1998, the Department of Elder Affairs and the Agency for Health Care Administration began the Long Term Care Community Diversion Pilot Project. CARES staff screens all individuals in need of nursing home care, giving them the choice of receiving services through a managed care provider or a fee-for-service option. If the individual chooses to participate in the managed care option, the HMO provider manages the individual's medical needs. The HMO providing the managed care for the Long Term Care Waiver in Pinellas County is The petitioner met a level of skilled care to be eligible for the Long Term Care Waiver. That level of skilled care is the same for Institutional Care Program benefits. The petitioner opted to participate in the managed care option Long Term Care Waiver through the HMO provider

The petitioner acknowledged and agreed to the policies of the Diversion Program including Conditions of Enrollment, Skilled Nursing Facilities and Voluntary Disenrollment. The petitioner was not eligible for custodial care in a nursing facility without prior authorization from The petitioner was aware of the requirement to notify her case manager prior to moving and the need for prior authorization from before entering a skilled nursing facility. The petitioner did not notify her case manager prior to moving nor did she receive prior authorization from before entering a skilled nursing facility.

The petitioner had a right at any time to disenroll from the Program. As set forth in Florida Administrative Code at 59G-8.100, the discontinuance of an enrollee's membership is as stated in the contractor's prepaid plan. The

Program is as outlined in their Disenrollment Procedure Policy. The disenrollment is effective at 12:00:01 a.m. of the first day of the month after a disenrollment form is received. The petitioner requested disenrollment on March 31, 2009. The first day of the month after a disenrollment form would have been May 1, 2009. The hearing officer concludes that the effective date for disenrollment was at 12:00:01 a.m., May 1, 2009. Based upon the above cited authorities, the respondent's action to deny payment to the nursing facility for custodial care in April 2008 was consistent with the regulations and statutes of the Program.

DECISION

This appeal is denied.

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 28th day of July, 2009,

in Tallahassee, Florida.

Linda Jo Nicholson

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