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

APPEAL NO. 09F-04029

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 16, 2009, at 2:20 p.m., in Miami, Florida. The petitioner was not present. The petitioner was represented by her brother, . The respondent was represented by Margaret Warner, senior human services program specialist, Agency for Health Care Administration (AHCA), and Robert Schemel, president of American Eldercare. Joy Styrcula, program analyst with the Department of Elder Affairs, was observing. Continuances were granted on behalf of the petitioner for hearings previously scheduled on August 12, 2009 and August 26, 2009.

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 from

September 19, 2008 to October 31, 2008, and to deny disenrollment effective June 2008.

FINDINGS OF FACT

1. The petitioner enrolled in the American Eldercare Long Term Care Diversion Program in 2004. American Eldercare Inc. is a provider for Medicaid Long Term Care Diversion Program. This program provides eligible individuals with quality care in a less restrictive setting than a nursing facility such as an assisted living facility (ALF) in order to avoid or delay nursing home placement.

2. The petitioner met the criteria for skilled care. The petitioner's medical condition was Alzheimer, incontinence of bladder and bowel, constipation, insomnia, high blood sugar, depression and psychosis.

3. The petitioner's representative signed an Acknowledgement of Program Purpose on June 15, 2007. The petitioner's representative acknowledged as follows: The enrollee was not eligible to choose to move into a nursing home for custodial care without the consent of American Eldercare. 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's

representative indicated that he received a copy of the American Eldercare Plan's Member Handbook/Provider Directory.

4. The American Eldercare 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 American Eldercare.

5. Prior to the action under dispute, the petitioner was residing in an ALF called The petitioner was responsible for room and board, but American Eldercare was paying for all other services.

6. On September 19, 2008, the petitioner's representative moved his sister to This nursing facility did not have a contract with American Eldercare.

7. According to Mr. the petitioner's representative did not contact the petitioner's case manager at American Eldercare prior moving her sister to a nursing home. According to Mr. on September 23, 2008, the care manager spoke with the petitioner's representative about the move, and at that time, he requested a disenrollment form.

8. Mr. explained that according to their records, the disenrollment request was not received until September 24, 2008. Mr. explained that the petitioner's representative was advised that the disenrollment

would not be in effect until November 1, 2008. In addition, Mr. Schemel explained the petitioner's representative was advised that bill would not be paid because the move was unauthorized and because this facility was not a member of their network.

9. In May 2009, requested payment for the petitioner's custodial care from September 19, 2008 through October 31, 2008. American Eldercare informed the facility that the petitioner was enrolled in the American Eldercare Plan and was not eligible for nursing home payment without prior authorization.

10. On June 3, 2009, the petitioner's representative requested an appeal to American Eldercare regarding the nonpayment for services for her sister for the above time period in question. On June 11, 2009, American Eldercare Appeals Committed denied this appeal.

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.

Following authorization by the 1997 Legislature, the Long-Term Care Community Diversion Pilot Project (Diversion project) was implemented in December 1998. The Diversion project is designed to serve the frailest individuals who would otherwise qualify for Medicaid nursing home placement, through the provision of long-term care services. The objective is to provide frail elders with community-based alternatives in lieu of nursing home placement at a cost less than Medicaid nursing home care. The provider for Long Term Care Waiver in Miami Dade County is American Eldercare. 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 provider American Eldercare.

The petitioner acknowledged and agreed to the policies of the American Eldercare Long Term Care 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 American Eldercare. The petitioner was aware of the requirement to notify her case manager prior to moving and the need for prior authorization from American Eldercare before entering a skilled nursing facility.

The petitioner's representative argues that on June 24, 2008, he refused to sign an Acknowledgement of Program Purpose form, because he was

relocating his sister The petitioner's representative purports that he wrote on the form the following notation: "I did not receive the previously requested disenrollment form from American Eldercare. Therefore I am hereby giving notice I will be relocating my sister ' am awaiting the approval date from the ... e & Hospital to whom I made application. Kindly mark your records accordingly. Any questions please contact me." The petitioner claims that since American Eldercare did not respond to his written request he then made an oral request. The petitioner's representative argues that on September 29, 2008, he submitted a Request for Disenrollment to American Eldercare with the following comments: "Made second request to American Eldercare for the disenrollment form in June 2008. I made the application a long time ago for and Hospital and received short notice of bed availability. Had to move sister, in 2 days or lose bed. I advised American Evercare of the flex situation by letter in June 2008. I requested disenrollment effective end of September 2008. Thank you. (Moved Sept. 19, 2008)"

The petitioner's representative argues that the American Eldercare's action is a violation of the enrollee's right to voluntary disenrollment by ignoring an oral and written request to disenroll, and by demanding that the disenrollment be done by signing a disenrollment form. The petitioner's representative argues that the enrollee's disenrollment date was erroneously extended by their self-interest and not by the interest of the enrollee.

Mr. Schemel argues that American Eldercare did not receive a request to disenroll the petitioner in June 2008. Mr. Schemel argues that the first time that they heard about the request was on September 29, 2008. Mr. Schemel explains that the earliest that the petitioner could be disenrolled was October 31, 2008, and that was what they did.

There is conflicting testimony and evidence concerning the date the petitioner's representative requested disenrollment of the petitioner from American Eldercare. However, it is not under dispute the fact that the petitioner's representative moved his sister to a skilled nursing facility on September 19, 2008, without first receiving prior authorization from American Eldercare.

Therefore, based on the evidence, the rules and the above cited authorities, the hearing officer finds that the respondent's action to deny payment to the nursing facility for custodial care for September 19, 2008 to October 31, 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 18th day of November 2009,

in Tallahassee, Florida.

Alfredo Fernandez

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