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

PETITIONER,

APPEAL NO. 09F-04311

Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
CIRCUIT: 18 Brevard
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 1:40 p.m. on October 10, 2009, in Cocoa, Florida. The petitioner was not present but was represented by , Esquire, with assistance of Also present on her behalf were her daughter and son-in-law, The respondent was represented telephonically by Debora Fridie, Esquire, assisted by Dean Kowalchyk, general counsel with Department of Elder Affairs (DOEA) and Tony DePalma, assistant general counsel. Also present telephonically were Kim Kellum, AHCA chief counsel; Bobette VanCott, ACCESS – Institutional Care Program supervisor with the Department of Children and Families (DCF); Keith Young, AHCA program analyst with the nursing home diversion project; Cheryl Young, AHCA manager of the nursing home diversion project; Joy Styrcula, DOEA contract manager;

and Robert Schemel, American Eldercare president. Lisa Sanchez, senior human service program specialist with AHCA was present.

ISSUE

At issue was whether denial of Medicaid waiver coverage under the Long-term Care Community Diversion Pilot Project (LTCCDPP) was correct. (The program is also known as the Nursing Home Diversion Program) Period in dispute is February, March and April 2009.

FINDINGS OF FACT

1. The petitioner (DOB ..._. , applied for Medicaid Home and Community Based Services (HCBS) under the Nursing Home Diversion (NHD) Program in late December 2008.

2. At that time, and throughout the period in question, the petitioner lived at an assisted living facility within American Eldercare's provider network. (American Eldercare has a contract arrangement with DOEA.)

3. During December 2008, DOEA–CARES completed a level of care evaluation on DOEA-CARES Form 603. It showed the petitioner "Meets Program Requirements For...LTCCDPP." Level of Care (LOC) was recommended as "Intermediate level I" with "Placement Recommendation" as "Community." Other level of care options on the form were "Withhold LOC...Does Not Meet LOC." Evidence did not establish the petitioner subsequently became independent or failed to meet a level of care.

4. As part of the December application for Medicaid assistance, the petitioner (authorized representative) signed DOEA–CARES Form 608. She

chose American Eldercare as provider for the Nursing Home Diversion Medicaid Long-Term Care Waiver Program. Section 4b, as checked, says:

> Yes, I choose to receive Nursing Home Diversion waiver services prior to being approved for Medicaid, and understand that in accordance with Section 430.705(5) Florida Statutes, **if I am determined ineligible for Medicaid, the Nursing Home Diversion provider may terminate services and seek reimbursement for those services from me** (emphasis included in the form). I also understand that the above Nursing Home Diversion provider will assist me in completing my application for determining Medicaid eligibility.

The document is Petitioner's Exhibit 1 as well as page 1, Respondent's Exhibit 1.

5. On December 31, 2008, DCF Economic Self-Sufficiency Services issued Certification of Enrollment Status Home and Community Based Services (HCBS), Respondent's Exhibit 1, page 2. It informed the petitioner "was enrolled in the Medicaid waiver (HCBS) to be effective on: 1/1/09..." The Case Management Agency was American Eldercare and the waiver program was "Nursing Home Diversion Program." The form was signed by a case manager.

6. On February 12, 2009, DCF issued HCBS Notices of Case Actions (pages 4-7 of Respondent's Exhibit 1) showing denial due to nonreceipt of information. DCF denied eligibility for months between December 2008 and February 2009.

7. The petitioner's family wrote checks to the assisted living facility on February 27, 2009 and on March 26, 2009. Amounts were $1022 and $3435, respectively (page 11 of Respondent's Exhibit 1).

8. The respondent indicated American Eldercare disenrolled the petitioner for the managed care program in February 2009. Disenrollment notice was not

entered into evidence. The respondent's witness, American Eldercare president, said his corporation provided some services and visits and received some capitation payment from the state. Business records of American Eldercare were not presented. No finding can be made as to disenrollment notification and status.

9. On April 7, 2009, DCF issued Notice of Case Action for HCBS – NHD. It said eligibility was denied effective January 1, 2009 (Respondent's Exhibit 1, page 8). Reason for denial was insufficient verification.

10. The petitioner reapplied for HCBS on April 10, 2009.

11. On April 30, 2009, DCF issued Notice of Case Action. It said that HCBS NHD was approved with "Effective Date: 01/01/2009," Respondent's Exhibit 1, page 9. The petitioner had established her financial eligibility with submission of necessary information.

12. On May 1, 2009, DCF also issued Notice of Case Action approving Medicaid effective January 2009, with the petitioner expected to pay "$0.00" to the provider (Petitioner's Exhibit 2). The DCF supervisor explained that the petitioner was financially eligible, but earlier denials were caused by missing verification. It is found that the petitioner was financially eligible between, at least, February through April 2009.

13. Approval for the HCBS-NHD has occurred and benefits were in place effective May 2009.

14. American Eldercare provides health maintenance options as contracted with DOEA. Medicaid pays capitation fees to providers such as

American Eldercare. The intent is helping individuals at risk of institutionalization live in a less restrictive environment. Portions of the contract were included in Respondent's Exhibit 1, pages 18-21. Enrollment and Disenrollment procedures are shown in Section 2.1.1. et seq. of the contract. The contract also addresses "Medicaid Pending" status in section 1.4.3. Section 2.1.1.17 addresses "Disenrollment Requested by the Contractor" as follows:

> (1) The contractor may request a disenrollment of an enrollee only for the following reasons:
> a. Enrollee death.
> b. Ineligibility for Medicaid.
> c. Ineligibility for the project.
> d. Moving outside the contractor's service area.
> e. Fraudulent use of the enrollee's Medicaid ID card.
> f. Incarceration.
> g. Non-cooperation, subject to department approval.

Disenrollment is also addressed at 2.1.1.18, saying, "(1) Disenrollment request forms must be completed in their entirety and submitted on EXHIBIT 1."

CONCLUSIONS OF LAW

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 Hearing to conduct this hearing pursuant to Florida Statute, Chapter 120.80. The Nursing Home Diversion Program requires joint efforts and communications between the Department of Elder Affairs, the Agency for Health Care Administration and the Department of Children and Families, as well as the contract provider and care facility.

The petitioner argued that the HCBS-NHD approval notices, and the factual financial circumstances, justify eligibility. The petitioner also argued that

semantics of Form 608 permitted eligibility. The respondent argued that Form 608 showed a risk was involved if Medicaid ineligibility was determined. The respondent argued that the February 2009 denial notices indicated disenrollment status and that American Eldercare could not provide payments in the absence of Medicaid eligibility. Moreover, from perspective of the respondent, it is acceptable to look forward into an eligibility period, but it is not acceptable to look retroactively.

Florida Statute 430.705 addresses "**Implementation of the long-term care community diversion pilot projects**." Section (2)(a) says the project is designed to "maximize the placement of participants in the least restrictive appropriate care setting." Section (5) informs significantly and in full as follows:

> A prospective participant who applies for the long-term care community diversion pilot project and is determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program within the Department of Elderly Affairs to be medically eligible, but has not been determined financially eligible by the Department of Children and Family Services, shall be designated "Medicaid Pending." CARES shall determine each applicant's eligibility within 22 days after receiving the application. Contractors may elect to provide services to Medicaid Pending individuals until their financial eligibility is determined. **If the individual is determined financially eligible, the agency shall pay the contractor that provided the services a capitated rate retroactive to the first of the month following the CARES eligibility determination. If the individual is not financially eligible for Medicaid, the contractor may terminate services and seek reimbursement from the individual**. (emphasis added)

In view of statutory language, it is concluded that retroactive eligibility is a possibility. It is further concluded that factors of an eligibility determination are highly relevant. If the individual is not financially eligible, then the diversion

program will not be available. If the individual is financially eligible, then the program could be authorized and may occur retroactively, if medical need exists. In this case, the CARES determination took place in December 2008 and was part of the known and official record. The CARES determination was for a level of care higher than Assisted Living Facility. The evidence did not show that CARES reduced the level of care or said "Does Not Meet LOC."

Section (10) says the Department of Elder Affairs "...is authorized to adopt any rules necessary to implement and administer the long-term care community diversion pilot projects..."

Florida Administrative Code informs in part as follows:

> **59G-13.080 Home and Community-Based Services Waivers.**
> (1) Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. ...
>
> **58N-1.009 Care and Service Standards.**
> (1) Medicaid Waiver Services: The provider must provide all Medicaid waiver services in accordance with its contract with the department.
> ...
> (5) Disenrollments:
> (a) In order to disenroll a participant from the diversion program, the diversion provider must follow the requirements outlined in its contract with the department.

In view of the administrative codes, used along with the contractual agreement [particularly (1)b], it is concluded that disenrollment could occur if an

individual were ineligible, but disenrollment would not occur if she were eligible. Inherent to an argument of disenrollment status would be a pre-existing status of enrollment. No evidence established that official disenrollment occurred. Thus, it cannot be concluded that disenrollment happened, and given the statute as combined with the rule plus evidence, it is concluded that disenrollment may not be required.

The state issued, on April 4, 2007, Transmittal #I-07-04-006 addressing "Medicaid Pending Initiative Long Term Care Community Diversion Program" as follows:

> This is to advise staff of a new initiative regarding the Department of Elder Affairs' Long-Term Care Community Diversion (LTCD) Program, the managed care Home and Community Based Services (HCBS) waiver program for elderly individuals in need of alternatives to nursing home care.
> This initiative does not involve any changes for ACCESS Florida eligibility staff, but in some instances, providers (instead of CARES) may be involved in the eligibility determination and providing verification to our staff on behalf of the client.
> Under the Medicaid Pending initiative, applicants may choose to receive services for the LTCD Program the month after CARES determines they are medically eligible, but before they are determined financially eligible. If the individual is determined eligible for the LTCD program, the providers will be paid for services provided during this time period, but they cannot bill for payment until after the individual is approved. If the individual is determined to be ineligible for the LTCD program, the provider must seek payment for the services directly from the individual.
> Participation in the Medicaid Pending initiative is voluntary for the clients as well as the providers. Not all LTC Diversion providers are participants in the Medicaid Pending initiative and current participants may opt out of the initiative at any time.
> Participating providers will assist a client in applying for Medicaid waiver benefits and should be treated like a designated representative with regard to confidentiality and the release of information. They may or may not actually become designated representatives for the client.

It is evident there is a risk of nonreimbursement if one pursues the diversion program. The transmittal and the DOEA-CARES Form 608 both describe such risk. An ineligibility determination could have an adverse impact on provider payments. Under the statute, the risk would be significant if there were financial ineligibility. However, in this case, a financial ineligibility determination did not occur. To the contrary, two notices of financial eligibility were issued by DCF showing retroactive eligibility to January 2009. There was no indication that health was restored to level of independence (otherwise stated, as the CARES form might show: "Does Not Meet LOC"). Findings of fact, as supported by adequate evidence, do not permit a conclusion that disenrollment status was assigned.

Based on the statute, the petitioner must have been enrolled with a HMO service provider and receiving services in order for there to be a retroactive payment to cover the services. If the petitioner was not enrolled and receiving services there would be no eligibility for retroactive payment although the petitioner may have otherwise been eligible for Medicaid. Enrollment forms were provided. At all times in question, the petitioner resided in an Assisted Living Facility and she received at least some services from the American Eldercare provider. Exact nature of services was not discernible from available evidence. Testimony of the corporate president was that his corporation provided some services for the petitioner. It is found that American Eldercare provided some services.

Careful and complete review of the findings, arguments, statutes, and regulations has taken place. It is concluded that ineligibility was not the necessary administrative determination. For months of February through April 2009, the situation met both financial eligibility and medical need requirements. Based on evidence, it is concluded the petitioner was medically in need of the program (CARES evaluation) and she met the financial standards (DCF determinations). Evidence did not establish she was not in medical need or not in financial need. Statute addresses this problem. The situation meets the eligibility requirements for the Home and Community Based, Nursing Home Diversion, long-term care community diversion pilot project. Thus, eligibility shall be authorized as requested.

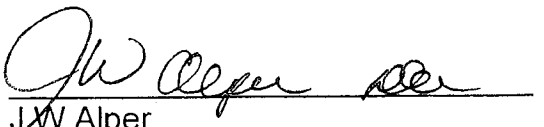
DECISION

The appeal is granted and the respondent's denial is not upheld.

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 6th day of November 2009, in Tallahassee, Florida.



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