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

APPEAL NO. 09F-07982

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 14 Holmes
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer telephonically on January 11, 2010, at 8:30 a.m. The petitioner was not present but was represented by her son, The Agency was represented by Amber Vaughn, acting field office manager, Agency for Health Care Administration (AHCA). Testifying on behalf of the respondent was Kay Brady, executive director, Walton County Counsel on Agency (WCCOA), Sandy Manning, case manager, WCCOA, and Pat Husted, Medicaid Waiver specialist, North West Florida Area Agency on Aging.

ISSUE

At issue is the September 3, 2009 action to terminate Home Delivered Meals under the Home and Community Based Service/Aid to Aged and Disabled Adult

Medicaid Waiver program effective September 30, 2009 based on the contention that the service does not meet medical necessity.

The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner (DOB January 16, 1918) is a recipient of Supplemental Security Income (SSI) and state plan Medicaid and Florida Aged and Disabled Adult Medicaid Waiver Services (A/DA). She has been diagnosed with Alzheimer's disease, high blood pressure, osteoporosis, diabetes, arthritis, dementia, heart problems visual problems, and GERDS.
2. The petitioner's son lives with her and is her primary caretaker.
3. A/DA waiver services are provided according to a written plan of care. The plan of care is based on an assessment of the recipient's need for home and community-based services. As services are based on the individual needs of each recipient, not every recipient receives every service
4. The waiver case manager is responsible for ensuring that home delivered meals satisfy at least one-third of the Recommended Daily Allowance (RDA) nutritional requirements and verify that the recipient cannot shop for groceries and prepare meals or that there is no caregiver capable of shopping for groceries and preparing meals.

5. Some of the services provided under the A/DA waiver are adult day health care, respite in-home, consumable medical supplies, caregiver training, home delivered meals, and nutritional risk reduction.
6. The availability of the service to waiver program participants is subject to approval by the Medicaid office and is subject to availability of the services under the specific waiver program for which the recipient has been determined eligible. The recipient's necessity for the services and appropriateness of the service is determined prior to approval of the plan of care.
7. Home delivered meal services provide meals delivered to the recipient's home for those who have difficulty shopping for groceries or preparing nutritious meals.
8. Prior to the action under appeal, the petitioner received respite services and home delivered meals based on an annual assessment in January 2009. The WCCOA completed an assessment instrument showing that the petitioner was unable to prepare meals for herself without help. The resources available to the petitioner were home delivered meals and caregiver prepared meals. At that time, the petitioner was approved for home delivered meals under Medicaid. The Respondent acknowledges that the services were approved in error.

9. A semi-annual review of the care plan on September 3, 2009 revealed that the petitioner did not qualify for Home Delivered Meals (HDM) according to the Medicaid Waiver Handbook as there was a caregiver capable of shopping for and preparing meals. Based on this review and the respondent's determination that it erred in providing HDM to the petitioner, a notice of termination of HDM was sent to the petitioner.

10. The caregiver does not agree with the respondent's action. It is his belief that no consideration was given to his ability to purchase and prepare meals for his mother. He is 66 years old and was diagnosed with prostate cancer several years ago. He had surgery for the condition on December 22, 2008. He goes to his physician two times a month for treatment of bladder control issues as a result of the surgical procedure.

11. The caregiver acknowledged that he is able to shop for and prepare his own meals and has been preparing meals for the petitioner. The petitioner attends adult day care three days a week from 4 to 5 hours a day to allow her to participate in activities and for socialization. The petitioner receives snacks and a meal while attending the adult day care activity. This provides the caretaker with respite. The caretaker attempts to go to medical appointments and handle shopping during this time. He considers the delivery of approximately 20 meals per month respite so that he is not responsible for planning, preparing and serving those meals to the petitioner.

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.

Fla. Admin. Code 59G-13.080 entitled "Home and Community-Based Services Waivers" states:

> (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. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.
> (2) Definitions. General Medicaid definitions applicable to this program are located in Rule 59G-1.010, F.A.C. Additional descriptions of services available under this program are provided in subsection (3) of this rule. The following definitions apply:
> (a) "Agency" means the Agency for Health Care Administration, the Florida state agency responsible for the administration of Medicaid waivers for home and community-based (HCB) services.
> (b) "Department" means the Florida Department of Elderly Affairs (DOEA).
> (3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Centers for Medicare and Medicaid under the authority of Section 1915(c) of the Social Security Act. The definitions of the following services are provided in the respective HCB services waiver, as are specific provider qualifications. Since several similar services with different names may be provided in more than one waiver, this section lists them as a cluster. A general description of each service cluster is provided. Individuals eligible for the respective HCB services waiver programs may need and receive the following services:...
> (n) Home Delivered Meals and Special Home Delivered Meals are

designed to provide meals to persons who have difficulty shopping for or preparing food without assistance.
... (4) Covered Services – General. Services provided under the HCB services waivers include those described in paragraphs (3)(a) through (ff). The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible.
(5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.
(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient. ...
(c) The Agency or its designee will conduct home visits of waiver program applicants or participants. Assessments of the applicant's or participant's home situation will be made to determine if it is acceptable in providing for his general health or safety. If the applicant's or participant's home situation does not provide for the applicant's or participant's general health or safety, the Agency shall restrict the applicant or participant from participation in the waiver program.... (f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service.
... (8) Case Management Requirements. ... Case managers will conduct a comprehensive needs assessment and identify areas in the person's life that require supports or services to reduce the risk of having to be placed in an institution. In addition, each case manager will:...
(b) Make a home visit as part of the needs assessment process;
(c) Prepare a written plan of care for each program participant and maintain the plan in the participant's case record;
(d) Reassess the plan of care at least every six months to review service goals, outcomes, and functional changes that may warrant the modification of the plan and reassessment of the recipient's level of care;
(e) After the needs assessment has been completed, maintain in each client's record case progress notes that document the provision of services;...

Florida Statute 409.913 addresses Oversight of the integrity of the Medicaid program, with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part that: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity..." Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services 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** (emphasis added).

The Florida Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook informs in Chapters 1 and 2 as follows:

> **Legal Authority** Medicaid home and community-based services (HCBS) wavier programs are authorized under Section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Part 441.302.

The Florida Medicaid Aged and Disabled Adult Waiver Program is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

Purpose of the A/DA Waiver
The purpose of the A/DA Waiver Program is to promote, maintain, and restore the health of eligible elders and adults with disabilities and to minimize the effects of illness and disabilities in order to delay or prevent institutionalization.

Plan of Care Review
The plan of care must be reviewed and updated to reflect the current needs of the recipient. For the purposes of case review, case managers must contact the recipient or caregiver at least every six (6) months, or more frequently depending on changes in the recipient's condition or living situation. The plan of care must be updated to reflect any changes.
The case manager must monitor the plan of care for continuity of services and ensure that changes in the recipient's status warrant service increases, service reductions, or other changes in the plan of care. This review is not a complete reassessment, but must address each problem included on the plan of care. The case manager must sign and date the plan of care at each review to certify that authorized services are appropriate and continue to be needed. Case reviews must be documented in the case narrative.

The above regulations and authorities explain that a Plan of Care review is updated to reflect current needs of the recipient.

The Florida Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, March 2004, page 10, describes Home Delivered Meals as follows:

Home Delivered Meals
Description
Home delivered meal services provide meals delivered to the recipient's home for those who have difficulty shopping for groceries or preparing nutritious meals.

Case Manager Responsibilities
The case manager must:

- Verify and document that recipient cannot shop for groceries and prepare meals and has no caregiver capable of shopping for groceries and preparing meals...

The above authorities explain that to receive Home Delivered Meals under the A/DA Waiver program, the recipient must be unable to shop for groceries or prepare meals or that the caregiver is not capable of performing those activities.

The Findings of Fact show that the petitioner is unable to shop for groceries or prepare meals. The caregiver who resides with the petitioner argued that the decision to terminate Home Delivered Meals did not take into consideration his limitations. The caretaker has been treated for prostate cancer and currently sees his doctor two times monthly. There was no testimony to show there are any limitations to shopping for groceries or meal preparation. He shops for groceries for himself and prepares his own meals in addition to some meals for the petitioner. The Findings show that the petitioner also receives some of her meals and a snack while attending adult day care three times a week.

The undersigned cannot find that the caregiver is unable to conduct shopping or meal preparation as his testimony demonstrates that he is able to conduct these activities on his own behalf.

Under governing statute and administrative guidelines, AHCA is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. According to

the above authorities, the agency or its designee shall approve plans of care based on the recipient's necessity for the services, and appropriateness of the service in relation to the recipient.

According to the above authorities, 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. As of the semi annual review of the Plan of Care in September 2009 and termination of HDM effective September 30, 2009, the information available from the case manager did not support the need for Home Delivered Meals as set forth in the above authorities. Available evidence supported the Respondent's action to discontinue HDM services as set forth on notice of September 3, 2009. It is concluded that the termination of the Home Delivered Meals was justified.

DECISION

The appeal is denied. The Agency's action is affirmed.

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 January, 2010,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
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Copies Furnished To