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

[redacted]

APPEAL NO. 14F-09327

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically in this matter before the undersigned hearing officer on December 16, 2014, at 3:45 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Son

For the Respondent: Sharon Garrison, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether the decision of the Agency for Health Care Administration to deny the petitioner's request for additional Home Health Aide ("HHA") services.

PRELIMINARY STATEMENT

[redacted] the petitioner's son, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. Mr. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Sharon Garrison, R.N., Registered Nurse Specialist/Fair Hearing Coordinator with the Agency for Health Care Administration, appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency for Health Care Administration: India Smith, Grievance and Appeals Coordinator for Sunshine Health; John Carter, M.D., Medical Director for Sunshine Health; Nayra Infanzon, Director of Case Management Services at Sunshine Health; and Jacqueline Alvarez, Long-Term Care Case Manager at Sunshine Health. Carol King, R.N., Registered Nurse Specialist/Fair Hearing Coordinator with the Agency for Health Care Administration, and Patricia Crawford, Supervisor of Case Management at Sunshine Health, were present solely for the purpose of observation.

The respondent introduced Exhibits "1" through 8", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

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 is an 82-year-old female.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is enrolled in Sunshine Health. Sunshine Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner has a history of Alzheimer's disease; Parkinson's disease; rheumatoid arthritis; high blood pressure; and high cholesterol.

5. The petitioner resides with her adult son, his wife, and her adult grandson.

6. The petitioner requires assistance with bathing; dressing; eating; transfers; ambulation; meal preparation; and housekeeping. The petitioner is incontinent and requires assistance with toileting. The petitioner ambulates with the assistance of a wheelchair.

7. The petitioner has a shower and bath chair as well as a commode in her bedroom. The petitioner sleeps in a hospital bed.

8. The petitioner's enrollment with Sunshine Health became effective August 1, 2014.

9. A Sunshine Health representative contacted the petitioner's representative on August 1, 2014 for the purpose of conducting a welcome orientation over the phone. During the telephone call on August 1, 2014, a face-to-face assessment was scheduled for August 4, 2014.

10. At the time of the face-to-face assessment, the petitioner was alert and oriented as to person and place but not as to time.

11. During the orientation visit on August 4, 2014, petitioner's representative requested eight hours of Home Health Aide services per day.

12. At the time of the orientation visit, petitioner's case manager suggested two hours of Home Health Aide services in the morning and two hours of Home Health Aide services in the later part of the day with the family supplementing the hours in between with privately paid aide. The petitioner's representative declined the four hours of Home Health Aide services per day.

13. The petitioner's son is a Sergeant in the United States Army and works from 6:00 a.m. to 4:00 p.m., Monday through Friday. The petitioner's son is her primary caregiver.

14. On August 6, 2014, the petitioner's representative again requested Home Health Aide services eight hours per day, seven days per week (a total of 56 hours per week).

15. The petitioner's request for Home Health Aide services eight hours per day, seven days per week, was not accompanied by a prescription from her primary care physician or clinical documentation to support the request.

16. On August 8, 2016, Sunshine Health sent a letter to the petitioner denying her request for coverage of eight hours per day, seven days per week explaining that the need for 56 hours of care exceed the recommended assessed hours and are not indicated at this time. The letter also explained that a total of 23 hours per week were approved for the petitioner. These 23 hours included 16 hours per week of personal care services, four hours per week of homemaking services, and three hours per week of respite. The petitioner began receiving these services on September 16, 2014.

17. Respite services are intended to provide relief to the primary caregiver so that he may have time to fulfill personal obligations unrelated to the care of the patient.

18. The petitioner's representative submitted a letter dated August 18, 2010 [*sic*] to Sunshine Health appealing the decision of Sunshine Health to only approve 23 hours per week. The letter explains: "I would like you to reconsider the facts identified to increase the care service hours from 23 to 48 hours a week, broken down at 8 hours daily on weekdays and 8 hours during weekends (4 on Saturday and 4 on Sunday.)"

19. On October 20, 2014, Sunshine Health authorized an additional five hours per week of respite care, increasing the total amount of authorized respite services to eight hours per week.

20. The petitioner currently receives personal care services and homemaking services in the amount of four hours per day, Monday through Friday, and respite care in the amount of eight hours per day on Saturday.

21. The petitioner presently receives personal care services and homemaking services from 8:00 a.m. to 12:00 p.m., Monday through Friday. Petitioner's grandson stays with her from the time the petitioner's son leaves for work in the morning until the time the petitioner's personal care assistant arrives. The family pays for a private aide to stay with the petitioner from 12:00 p.m. until someone arrives home from work.

22. The petitioner's Long Term Care Plan of Care signed by the petitioner on November 3, 2014 indicates the petitioner requires personal care services to maintain safety while performing her activities of daily living in the amount of four hours per day on Monday and three hours per day Tuesday through Friday. The same Plan of Care indicates the petitioner requires homemaker services in the amount of one hour per day Tuesday through Friday.

23. The petitioner's CARES Assessment indicates that she would qualify for placement in an Assisted Living Facility ("ALF").

24. The Sunshine Health representative testifying at the hearing explained that Sunshine Health would potentially pay for the costs associated with having the petitioner reside in an Assisted Living Facility.

25. The petitioner's family believes the petitioner can receive better care in the family home and does not wish to institutionalize the petitioner.

26. The petitioner was offered participation in the Participant Direction Option program. This program allows a member to choose a worker other than a Home Health Aide to provide services and may offer greater flexibility with regard to being able to secure more services. Petitioner's representative declined participation in this program.

27. The petitioner requires monitoring and supervision due to her Alzheimer's disease.

CONCLUSIONS OF LAW

28. 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 Chapter 120.80, Fla. Stat.

29. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

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

31. The petitioner in the present case is requesting an increase in her Home Health Aide services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

32. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

33. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

34. 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. ...
> (c) The agency may not pay for home health services unless the services are medically necessary ...

35. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

36. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 180.

37. The Florida Medicaid Home Health Services Coverage and Limitations Handbook March 2013 ("Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.130(2). The Handbook describes the Home Health Services Program, which consists of various services including: Registered Nurse services; Licensed Practical Nurse services; and Personal Care Services.

38. Page 1-2 of the Handbook states "Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability."

39. Page 1-2 of the Medicaid Handbook provides a list of personal care (ADL) services. These services include:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and

- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions.

40. With regard to managed care, per Fla. Stat. § 409.965:

All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:
(1) Women who are eligible only for family planning services.
(2) Women who are eligible only for breast and cervical cancer services.
(3) Persons who are eligible for emergency Medicaid for aliens.
History.—s. 6, ch. 2011-134; s. 4, ch. 2014-57.

41. Fla. Stat. § 409.972 adds to the list of those exempt, noting:

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:
(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).
(c) Persons eligible for refugee assistance.
(d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.
(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
(f) Medicaid recipients residing in a group home facility licensed under chapter 393.
(g) Children receiving services in a prescribed pediatric extended care center.
(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.
(3) The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

42. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for her Long-Term Care needs.

43. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Sunshine Health.

44. 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.

45. 42 CFR 438.210 Coverage and authorization of services addresses the contractual requirements of agreements between states and managed care organizations and explains as follows:

> (b) ***Authorization of services.*** For the processing of requests for initial and continuing authorizations of services, each contract must require—
> ...

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

46. In accordance with 42 CFR 438.210, the decision to deny the service authorization request in the instant matter was made by a health care professional.

47. In the present case, the petitioner requested personal care services eight uninterrupted hours per day, seven days per week. The petitioner's representative presented little to no evidence at the hearing to demonstrate that the additional services requested are for anything other than supervision and monitoring, or anything from a health care professional indicating that the additional services are medically necessary. Much of the representative's testimony focused on his needs rather than those of the petitioner. Although the intent of the Waiver program in which the petitioner participates is to assist individuals in avoiding institutionalization, personal care services are intended to provide an individual with assistance in completing activities of daily living. Supervision and monitoring, although important tasks, do not fall within the definition of activities of daily living.

48. Pursuant to the above, the petitioner has not met her burden of proof that the Agency incorrectly denied her request for additional personal care services.

DECISION

The petitioner's appeal is hereby 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28th day of January, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

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