

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

**FILED**

**AUG 04 2014**

OFFICE OF APPEAL HEARINGS  
DEPT OF CHILDREN & FAMILIES



APPEAL NO. 14F-03937

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION (AHCA)  
CIRCUIT: 14 Calhoun  
UNIT: 88113

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, an administrative hearing in the above-referenced matter was convened telephonically on June 20, 2014 at 10:17 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED] administrative caretaker [REDACTED]  
[REDACTED]

For the Respondent: Stephanie Cortes, RN specialist with AHCA

**STATEMENT OF ISSUE**

At issue is the correctness of the respondent's action terminating the petitioner's enrollment in the Medicaid Long Term Care Program (Medicaid LTCP).

**PRELIMINARY STATEMENT**

By notice dated March 18, 2014, the respondent informed the petitioner that her enrollment in the Medicaid LTCP was being terminated effective March 31, 2014. The notice reads in relevant part:

This letter is to let you know that you are not currently eligible for the Statewide Medicaid Long-term Care program and were enrolled in error. Since an enrollee must be eligible according to section 409.979, Florida Statute (2013), your enrollment in the Long-term Care program will end on March 31, 2014. Your Long-term Care plan will also stop paying for service on this date. ...

On March 21, 2014, the petitioner timely requested a hearing to challenge the respondent's decision.

The petitioner was present and designated [REDACTED] to represent her in this matter. The petitioner did not testify.

Vicky Sexton, government analyst with Department of Elder Affairs (DOEA) was present as a witness for the respondent. Respondent Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on July 11, 2014 for the submission of additional information and to allow the respondent an opportunity to re-review its decision in this matter. Documentation was timely received from both parties and admitted into evidence as Respondent's Composite Exhibit 2 and Petitioner's Composite Exhibit 1.

**FINDINGS OF FACT**

1. The Agency for Health Care Administration (or respondent) administers the Medicaid program. The Department of Elder Affairs (DOEA) performs Level of Care

determinations for applicants seeking Medicaid waiver services and nursing home services.

2. In late 2013, the Medicaid LTCP replaced several other Medicaid waiver programs (including Assisted Living, Aged and Disabled Adult, Consumer-Directed Care Plus, All-inclusive Care for the Elderly, Long-term Care Diversion, and Channeling Services).

3. To qualify for participation in the new Medicaid LTCP, an individual must meet the age and/or disability criteria, have the necessary Level of Care (assessment form which designates that the applicant/recipient meets the medical criteria for nursing home services), and reside in a nursing facility or have been enrolled in one of the terminated waiver programs.

4. Individuals who were enrolled in one of the terminated waiver programs were automatically converted to the Medicaid LTCP; they are eligible for the Medicaid LTCP for 12 months without being reevaluated.

5. The respondent ran a report of individuals who had both a nursing home Level of Care and were active in the Medicaid system. These individuals were enrolled in the new Medicaid LTCP, without further evaluation. The respondent later discovered that some of the individuals it had enrolled in the new Medicaid LTCP did not reside in a nursing facility and had not been previously enrolled in one of the terminated waivers. The respondent determined that these individuals did not qualify for participation in the new Medicaid LTCP and terminated their waiver enrollment.

6. The petitioner [REDACTED] was enrolled in the Medicaid LTCP when her circuit converted to the new waiver in November 2013. At that time of conversion the petitioner was receiving Medicaid (SSI recipient) and had a Level of Care (to cover temporary nursing home stay for rehabilitation petitioner received April 2013 through June 2013). The petitioner was not living in a nursing facility and was not participating in one of the terminated Medicaid waiver programs in November 2013.

7. The respondent concluded that the petitioner was one of the individuals it enrolled in the Medicaid LTCP in error. The respondent terminated the petitioner's enrollment effective March 31, 2014. The petitioner was enrolled in the Medicaid LTCP November 2013 through March 2014.

8. The petitioner suffers from seizure disorder and schizophrenia. The petitioner cannot manage on her own; she needs assistance with meal preparation, administration of medication and monitoring of her seizures. The petitioner has been living at [REDACTED] ALF since February 2014. (Prior to admission, she had been in a mental hospital, an ALF and a nursing home.) Her current payer source is Supplemental Security Income (SSI), \$721 monthly. The ALF monthly charge is \$2,600 monthly. The petitioner needs another funding source to cover the difference.

9. [REDACTED] administrative caretaker, testified that the ALF believed that the petitioner was correctly enrolled in the Medicaid LTCP at the time of admission, in February 2014. The ALF believed the Medicaid LTCP would cover the ALF charges in excess of the petitioner's SSI income. The ALF later learned that her waiver services had been terminated and has been talking to both the respondent and

DOEA trying to determine what was needed to reinstate her Medicaid LTCP coverage.

The ALF believed that the petitioner only needed a new Level of Care from DOEA in order to have the Medicaid LTCP coverage reinstated.

10. The respondent was not aware that the petitioner was receiving ALF services prior to the hearing. However, DOEA shows a request for Level of Care was received for the petitioner in early 2014. On February 6, 2014, DOEA concluded the petitioner's needs were beyond what could be provided at an ALF and that she required nursing home services. DOEA has received no additional Level of Care requests for the petitioner.

11. After hearing the petitioner's case, the respondent requested an opportunity to re-review the petitioner's eligibility for the Medicaid LTCP. A decision was due from the respondent on July 11, 2014.

12. On June 27, 2014, an electronic communication was received from the respondent. It reads in relevant part:

██████████ was given a temporary level of care effective 4/3/13. ██████████ was sent a letter on 3/3/14 stating she was enrolled with American Eldercare for LTC. This plan was entered into FMMIS but then put in history. This means the plan never took effect. ██████████ received a letter dated 3/18/14 stating she was not currently eligible for Statewide Medicaid Managed Care Long Term Care Program... ██████████ is not eligible for Long Term Care services based on 2013 Florida Statutes 409.979... Ms. ██████████ is not currently enrolled in and DOEAs not have an open date span of enrollment in the American Eldercare LTC plan. American Eldercare would issue to the ALF a paper that states it is a service authorization if they approved payment for services. My understanding is that the ALF has nothing in writing to authorize the services being provided to Ms. ██████████ Since ██████████ was not enrolled in American Eldercare, therefore they could not have given authorization. In order to request a reinstatement into the LTC plan and to submit her to CARES for a level of care assessment, we would need documentation showing the plan

authorized services. We cannot find where services were authorized due to the fact that she was not enrolled in the plan.

The respondent concluded that the petitioner was not eligible for continued benefits pending the outcome of the hearing because she never actually received Medicaid LTCP services.

### **CONCLUSIONS OF LAW**

13. 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 § 120.80, Fla. Stat.

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

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

16. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the respondent.

17. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7<sup>th</sup> Ed.).

18. Eligibility for the Medicaid LTCP is forth at Fla. Stat. §409.979

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

(2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):

(a) The Assisted Living for the Frail Elderly Waiver.

(b) The Aged and Disabled Adult Waiver.

(c) The Consumer-Directed Care Plus Program as described in s. 409.221.

(d) The Program of All-inclusive Care for the Elderly.

(e) The long-term care community-based diversion pilot project as described in s. 430.705.

(f) The Channeling Services Waiver for Frail Elders.

(3) The Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before enrollment offers, the department shall determine that sufficient funds exist to support additional enrollment into plans.

19. The findings show that the respondent erroneously approved the petitioner for the new Statewide Medicaid LTCP when converting her circuit to the new waiver program in November 2013. The findings show that the petitioner did not qualify for enrollment in the new waiver because she had not been enrolled in one of the terminated waivers and she was not living in a nursing home at the time of the conversion. The respondent terminated the petitioner's waiver coverage effective March 31, 2014.

20. The petitioner has been living in [REDACTED] ALF since February 2014. The ALF admitted her because it believed that she was eligible for Medicaid LTCP funding. Prior to admission into [REDACTED] ALF, the petitioner was in and out of the hospital, an

ALF and a nursing home. She was discharged from the nursing home on June 13, 2013.

21. The controlling legal authorities state that in order to qualify for Medicaid LTCP enrollment an individual must meet **ALL** (emphasis added) of the following criteria: have been enrolled in one of the terminated waivers or have been living in a nursing home at the time of the conversion; be age 65 or older or age 18 and eligible for Medicaid due to a disability; have the necessary Level of Care.

22. AHCA converted the petitioner's region to the Medicaid LTCP in November 2013. The petitioner was not residing in a nursing home, nor was she enrolled in one of the terminated waivers at the time of the conversion. The petitioner did not meet the statutory criteria for participation in the Medicaid LTCP.

23. The undersigned notes that the agency gave notice of approval and then gave notice in the same month of termination from the new Medicaid LTCP. State agencies have a responsibility to enroll only eligible individuals in any Medicaid Program. In this case, the respondent approved petitioner for a Medicaid Program she was not eligible for. Once discovered, the respondent did the only thing it could do in notifying petitioner of the mistake. This action led to much confusion among the staff trying to assist petitioner and possibly delayed petitioner from making a different placement choice. The undersigned recognizes that hardship. However, due to the above statute setting forth the individuals eligible for the new Medicaid LTCP, the undersigned cannot conclude petitioner met the eligibility criteria for conversion to this Medicaid Waiver Program and cannot order a favorable outcome.



24. Petitioner remains eligible for Medicaid; she is currently not eligible for the Waiver Program that would have paid for her cost of care at the ALF.


**DECISION**


Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 4<sup>th</sup> day of August, 2014,  
in Tallahassee, Florida.

  
Leslie Green  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
Email: Appeal\_Hearings@dcf.state.fl.us

Copies Furnished To:  Petitioner  
Marshall Wallace, Area 2, AHCA Field Office Manager