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

[redacted]

APPEAL NO. 15F-07433

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on October 20, 2015, at 3:15 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner

For the respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's respite services?

PRELIMINARY STATEMENT

[redacted]("petitioner"), the petitioner, appeared on her own behalf.

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator at the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Sunshine Health appeared as witnesses on behalf of the Agency: India Smith, Grievance and Appeals Coordinator; John M. Carter, M.D., Long-Term Care Medical Director; Mayra Infanzon, Executive Director of Service Area 4; Lisa Frischkorn, Long-Term Care Case Management Supervisor; and Merlyn Grant, Long-Term Care Case Manager.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, 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 a 61-year-old female.

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

3. The petitioner is an enrolled member of 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's effective date of enrollment with Sunshine Health was May 1, 2014.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner's medical history is remarkable for the following: [redacted]

7. The petitioner was previously approved to receive the following services: 14 hours per week of respite; 14 hours per week of personal care; and 7 hours per week of homemaker.

8. In a Notice of Action dated August 12, 2015 (*Resp. Exhibit 2*), Sunshine Health informed the petitioner it was terminating her respite services.

9. The Notice of Action (*Resp. Exhibit 2*) states, in part:

> Sunshine Health has reviewed your request for terminating (stopping) your Respite Care Service (The care given in your home to help give your caregiver a break) 2 hours x7 days per week, which we received on 07/28/2015. After our review, per your request, this service has been: TERMINATED (stopped) as of 08/21/2015.
>
> X We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
>
> X Other authority: Based on member's request.
>
> You asked to terminate (stop) your Respite Care service (The care given in your home to help give your caregiver a break) because there is no live-in care giver in the home.

10. The petitioner did not request termination of her respite services.

11. The respondent's witnesses testified Sunshine Health's decision to end the petitioner's respite services was the result of information documented by the

petitioner's case manager in a face-to-face assessment with the petitioner on July 27, 2015.

12. Evidence introduced by the respondent pertaining to the July 27, 2015 face-to-face assessment (*Resp. Exhibit 1*) states the following:

> On 7/27/2015 [Case Manager] went to member's home to perform a face to face assessment. On this date, the member lives at home with her spouse whom is disabled with a "bad Hip" During the face to face it was established that the member required some assistance, but not total assistance, with her activities of daily living (ADL's) such as bathing, dressing, and using the bathroom. The member does not require assistance with eating and uses an assistive device for transferring and walking. However, during member's face to face visit member was observed walking to the bathroom without her walker as well as not using incontinent supplies. Individual Activities of Daily Living (IADL's) member needs total assistance with heavy chores and needs some assistance with housekeeping, preparing meals, shopping, managing medications, and using transportation. Member does not need assistance with using the phone or managing money.
>
> Member admitted to cooking sometimes and stated that the aide comes in and does a little of everything for both the member and the member's spouse. Member advised her spouse is not the caregiver, and does not want to take on the role of the caregiver and there is no other live-in caregiver at this time. Based on the given information the member's respite hours were set to be termed as of 7/31/2015. An NOA was sent to the member & agency Almost Family dated 8/12/2015 advising respite hours are to stop as of 8/21/2015.

13. Because of a 10-day notice of adverse action requirement, Sunshine Health was unable to terminate the petitioner's respite services on August 21, 2015. However, it did end these services effective August 31, 2015.

14. The respondent's witnesses testified at the hearing the petitioner's respite services were terminated based on the premise that there is no caregiver present in the petitioner's home.

15. The petitioner testified at the hearing that her husband is her caregiver.

16. Petitioner's husband is 64-years-old and suffers from a [redacted]

17. The petitioner's husband assists the petitioner with all of her activities of daily living including bathing and dressing. The petitioner is unable to lower herself into the bathtub independently and requires the assistance of her husband.

18. Although the petitioner's husband has a disability, it does not prevent him from being the petitioner's caregiver. The hearing officer finds the petitioner's husband is her caregiver.

19. The narrative provided by the respondent (*Resp. Exhibit 1*) states the petitioner was observed ambulating to the bathroom without an assistive device.

20. The petitioner ambulates short distances with the assistance of a walker. She uses a motorized wheelchair to ambulate longer distances. The petitioner is unable to walk independently.

21. The petitioner cannot walk up the stairs. She uses a chair lift to assist with this activity.

22. The petitioner's Long Term Care Plan of Care (*Resp. Exhibit 3*) introduced by the respondent at the hearing indicates that respite services are required to "prevent burnout of caregiver". Although the Plan of Care has a typewritten effective date of May 1, 2014 and reflects that respite services are requested from May 1, 2014 through July 31, 2014, there is a handwritten date of July 27, 2015 on the upper right hand corner of the first page of the Plan of Care. The respondent's witness testified at the hearing this Plan of Care was completed by the petitioner's Case Manager pursuant to information gathered at the July 27, 2015 face-to-face assessment.

23. The 701b Comprehensive Assessment (*Resp. Exhibit 4*) completed by the petitioner's Case Manager as a result of the face-to-face assessment completed on July 27, 2015 rates the petitioner's overall health as poor. It explains the petitioner is a fall risk and that the petitioner has visited the emergency room five times within the past year.

CONCLUSIONS OF LAW

24. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.

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

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

27. In the present case, the respondent has terminated previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

28. 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.).

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

30. 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…

31. 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.

32. 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 § 440.180.

33. 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 the Agency for Health Care Administration to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Sunshine Health.

34. 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.

35. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

36. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

37. Respite services are not available through the Agency for Health Care Administration. Therefore, it cannot be said that the provision of these services by Sunshine Health is in any way more restrictive than the provision of these services by the Agency for Health Care Administration.

38. The LTC (Long Term Care) Ancillary Service Criteria (*Resp. Exhibit 5*), the Contract between the Agency for Health Care Administration and Sunshine Health governing the Long-Term Care Program, on Page 5, describe Respite Care as follows:

> Services provided to members unable to care for themselves furnished on a short-term basis due to the absence or need for relief of the persons normally providing the care. Respite services are only provided on the basis of need to relieve the primary caregiver. Respite cannot be approved if the member's caregiver must work and the member requires constant supervision and cannot be left alone in the absence of the caregiver. Other appropriate services must be considered, such as Adult Day Care or Adult Companion services when a caregiver works. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility. Respite in-home services must be provided at the member's residence. Facility-based respite services must be provided in a Medicaid-certified nursing facility, a licensed adult day care facility or licensed assisted living facility.

39. The respondent's witnesses testified the petitioner's respite services were terminated due to the absence of a caregiver in the home. They proffered no argument that the other services in place could provide the care contemplated by these services.

40. Since it has been determined there is a caregiver in the home – the petitioner's husband, the respondent has not met its burden of proof to show that it correctly terminated the petitioner's respite services.

41. After careful consideration, the hearing officer concludes the respondent incorrectly terminated the petitioner's respite services.

DECISION

The petitioner's appeal is hereby GRANTED. The respondent is instructed to reinstate the petitioner's respite services.

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 30 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

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