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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07559

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on October 27, 2015, at 1:10 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner's daughter

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

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for an additional 10 hours of long-term care services comprising of any combination of companion services and respite services?

PRELIMINARY STATEMENT

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

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Amerigroup appeared as witnesses on behalf of the Agency: Mary Colburn, M.D., Long-Term Care Medical Director; and Carlene Brock, L.P.N., Quality Operations Nurse.

The petitioner introduced Exhibits "1" and "2", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 3, 2015 in order for the respondent to submit the relevant portion of the contract between the Agency for Health Care Administration and Amerigroup and the Amerigroup Long-Term Care Member Handbook. Once received, this information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was then closed.

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. Petitioner is an 86-year-old female residing in [redacted] Florida.

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

3. The petitioner is an enrolled member of Amerigroup. Amerigroup 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 Amerigroup was November 1, 2013.

5. The petitioner is a bilateral lower extremity amputee. She is diagnosed with the following: [redacted]

6. The petitioner requires assistance with all of her activities of daily living. She can no longer be placed in the shower and must be given bed baths.

7. The petitioner uses a bed pan to evacuate her bladder and bowels.

8. The petitioner was hospitalized due to dehydration and renal failure from August 23, 2015 through August 29, 2015. She was re-hospitalized from September 4, 2015 through September 12, 2015.

9. The petitioner has been very weak since returning home from the hospital. Although the petitioner requires hydration, she is too weak to hold a glass of water and drink independently. She requires the assistance of another individual to drink. She also requires the assistance of another person to take her medication.

10. The petitioner presently requires a two-person assist for transfers.

11. The petitioner lives in the family home with her representative, another adult daughter, and her adult son.

12. The petitioner's representative is her primary caregiver.

13. The petitioner's primary caregiver works from 10:00 p.m. to 10:00 a.m., three nights per week. On the days on which the petitioner's primary caregiver works, she must sleep during the day.

14. Petitioner's representative recently underwent a cardiac catheterization due to a heart condition.

15. Due to her heart condition and other medical limitations, the petitioner's representative can no longer assist the petitioner as extensively as she did previously. She is no longer able to assist the petitioner with transfers.

16. The petitioner's other adult daughter and her adult son are able to assist the petitioner in the evenings when they return home from work.

17. The petitioner is presently approved to receive 26 hours per week of long-term care services. The specific services approved are as follows: 14 hours per week of Personal Care services; four hours per week of Homemaker services; four hours per week of Companion services; and four hours per week of Respite services. These services total 26 hours per week.

18. The petitioner normally allocates the 26 hours per week as follows: six hours per day, three days per week; and two hours per day the remaining four days of the week.

19. On August 11, 2015, the petitioner requested an additional 10 hours per week of long-term care services. The services formally requested were companion services or respite services.

20. The petitioner's representative explained at the hearing she is not familiar with the individual types of services available under the long-term care program, nor does she care what type of services are approved, as long as her mother receives the additional care she requires.

21. In a Notice of Action dated August 18, 2015, Amerigroup notified petitioner that her request for additional services was denied. Although the Notice only addresses respite services, the parties testified the petitioner requested 10 hours of either respite care or companion services.

22. The Notice of Action states, in part:

> ■ 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)*
>
> > ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. …

23. The petitioner normally goes to bed around 10:00 p.m. and gets out of bed at 9:30 a.m. or 10:00 a.m.

24. The petitioner has difficulty sleeping at night due to phantom limb pain. That is why she gets out of bed so late in the morning.

25. The petitioner was attending [redacted] on multiple days of the week prior to her hospitalization. [redacted] is an exercise class at a local hospital. The petitioner was attending the class to help build and maintain her upper body strength.

26. The petitioner's condition has deteriorated to the point where she can no longer attend [redacted]

27. The petitioner's Plan of Care and 701b Comprehensive Assessment were completed prior to her two most recent hospitalizations. These evaluations reflect the petitioner's condition and service needs at that time.

28. The petitioner's service needs have intensified since the time her Plan of Care and 701b Comprehensive Assessment were completed. The Plan of Care and 701b no longer accurately reflect the petitioner's needs.

29. It is the position of the petitioner's representative that both the petitioner's health and her health have deteriorated and additional services are necessary to ensure the petitioner's health and safety.

30. It is the respondent's position that the presently approved services are sufficient to assist the petitioner with her basic needs if they are allocated differently.

CONCLUSIONS OF LAW

31. By agreement between the Agency for Health Care Administration 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.

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

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

34. In the present case, the petitioner is requesting additional services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

35. 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.).

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

37. 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…

38. 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.

39. 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.

40. 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 Amerigroup.

41. 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.

42. 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.

43. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

44. 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."

45. In the present case, the services contemplated are available under the long-term care program but not under Medicaid. Therefore, it cannot be said that the provision of these services by Amerigroup is more restrictive than the provision of these services by the Agency for Health Care Administration.

46. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 11 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Adult Companion Care as follows:

> Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

47. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Pages 13 and 14 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Homemaker Services as follows:

> General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

48. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Personal Care as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

49. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Respite Care as follows:

> Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. 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.

50. In the present case, the petitioner's condition has deteriorated since her two most recent hospitalizations resulting in an increase in her service needs. In addition, the petitioner's primary caregiver has physical limitations which limit her ability to provide care to the petitioner and, furthermore, the primary caregiver works overnight and needs to sleep during the day while the petitioner is awake. The services presently

approved for the petitioner are not adequate to provide her with the care necessary to ensure her health and safety and prevent institutionalization.

51. Pursuant to the above, the petitioner has met her burden of proof to show the respondent incorrectly denied her request for additional long-term care services.

DECISION

The petitioner's appeal is hereby GRANTED. The respondent is hereby ordered to provide an additional 10 hours of respite services per week.

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 01 day of December, 2015, in Tallahassee, Florida.

Peter J. Tsamis

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