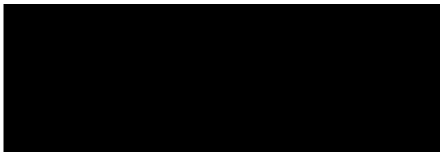
FILED

Feb 04, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 15F-07619

PETITIONER,

vs.

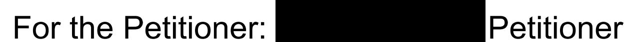
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Marion
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened administrative hearing in the above-captioned matter on October 22, 2015 at approximately 11:30 a.m. and November 3, 2015 at approximately 3:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES



For the Petitioner: Petitioner

For the Respondent: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or “the Agency”) through the Department of Elder Affairs (DOEA), to terminate Petitioner’s enrollment in the Medicaid Long Term Care (LTC) Program. Respondent

bears the burden of proving, by a preponderance of the evidence, that said termination/disenrollment is proper.

PRELIMINARY STATEMENT

Via Notice of Hearing, both parties were informed that this matter would convene for telephonic hearing on October 22, 2015 at 11:30 a.m. Prior to hearing, Respondent AHCA, represented by Selwyn Gossett, filed a Motion to Dismiss. At hearing on October 22, 2015, the Agency was present on the conference line, along with witnesses from Petitioner's LTC health plan (United Healthcare Community Plan), and from the DOEA's Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit.

While ruling that dismissal of the appeal was denied, the undersigned rescheduled hearing for November 3, 2015 so as to research whether AHCA or the Department of Children and Families (DCF) was the proper respondent to this appeal. It was CARES' opinion that AHCA was the correct respondent, because Petitioner's disenrollment was based strictly on medical eligibility.

When hearing convened on November 3, 2015, Mr. Gossett again appeared as the Agency's representative. Appearing as Respondent's witnesses from Petitioner's former LTC health plan, United Healthcare Community Plan (United), were Christian Laos, Senior Compliance Analyst, and Marc Kaprow, D.O, Executive Director of the Long Term Care Plan. Appearing from the DOEA CARES Unit were Susan Hanley, Ocala Program Operations Administrator, and Jane Bendula, Senior CARES Assessor. Petitioner appeared as her own representative and witness. Sara Catherine Spillers,

Esq., Assistant General Counsel, and Hearing Officer Greg Watson, observed the proceedings without objection from either party.

Respondent's Exhibits 1 through 8, inclusive, were entered into evidence. The record was held open so that Respondent might provide the following, additional documentation:

- Notice of LTC Termination via Health Tracks
- Certification of re-sending evidence packet from 10/04/15 (Petitioner did not receive)
- Notice of Case Action from United LTC
- Form 834 file (showing active/terminated enrollment) from United

Petitioner requested a copy of this supplemental documentation for her records, as well as a copy of the original evidence packet. Upon review of the supplement, it was determined that a copy had not been furnished to Petitioner, and that no certification of service documenting re-mailing of the original packet was filed. The undersigned issued an Order Sharing Supplement to accomplish provision of all evidence to the Petitioner. Said Order also gave Petitioner until January 4, 2016 to file any response to same. No further correspondence from Petitioner was received.

Respondent's supplemental evidence is hereby entered, as follows:

▪ Respondent's Exhibit 9: Notification from AHCA's Helpline, dated August 14, 2015 (1 page)

▪ Respondent's Exhibit 10: November 5, 2015 e-mail from Christian Laos of United (2 pages)

▪ Respondent's Exhibit 11: Disenrollment information (chart form, one page).

FINDINGS OF FACT

Based upon 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 a 65-year-old female. Prior to the action under review, Petitioner was determined to meet a certain Level of Care, and was receiving benefits through a Long Term Care (LTC) Home and Community-Based Services (HCBS) Plan, via United Healthcare. United Healthcare is contracted by AHCA to provide services to LTC recipients

2. The Comprehensive Assessment and Review for Long-term Care Services (CARES) unit of the DOEA operates under the regulatory oversight of AHCA via inter-agency agreement, and is mandated to conduct Level of Care (LOC) assessments for individuals applying for or receiving LTC services. On or about July 10, 2015, United requested that CARES complete an annual recertification review and LOC for Petitioner.

3. Following a desk/file review of United's own assessment, CARES determined that Petitioner did not appear to meet Level of Care requirements to continue under the LTC Waiver; however, CARES scheduled a face-to-face assessment of their own, to evaluate Petitioner's continued eligibility.

4. On July 20, 2015, CARES completed its own Comprehensive Assessment (701B), which documents Petitioner's responses to prompts regarding her status and health care needs and is designed to evaluate a recipient's functionality, mental status, medication, and therapeutic requirements. Petitioner's Assessment notes that she is alert and oriented, in fair health, and feels about the same as she did in July of the

previous year. Petitioner requires total assistance with heavy chores, and some assistance with housekeeping; however, she is able to complete her activities of daily living (ADLs), and can prepare her own meals, manage money and medication, shop, and use transportation, on her own. She is able to climb two or three steps, requires no assistance with bathing, dressing, eating, or preparing meals, does not use any medical gasses, does not undergo bladder/bowel treatment, does not require wound care, nor does she participate in therapies. She properly manages her own medication, but does not participate in activities outside the home. The Petitioner suffers from , She has occasional has and uses a She is on a low sodium diet, takes approximately six medications per day, and (at the time of the assessment) was receiving home delivered meals. She was noted to be 5 feet, 8 inches tall, and to weigh approximately 400 pounds, and found to *not* be at imminent risk of nursing home placement.

5. CARES also reviewed Petitioner's medical records and medical progress notes. Notes from a doctor's visit on or about April 1, 2013 reflect diagnoses/a medical history including

6. Following completion of the 701B, CARES conducted a staffing meeting on or about August 11, 2015, to review Petitioner's Assessment, medical records, and medical progress notes with the Program Operations Administrator and with CARES' physician consultant. CARES determined that Petitioner *does* need assistance with

housekeeping, but does not meet the LOC required for LTC services. Case Recording Form notes generated after said meeting reflect, in part:

> The client has been diagnosed with chronic medical conditions including [redacted], [redacted] Client does not meet Level of Care due to not requiring extensive health related care and client is not physically or mentally incapacitated. She does exhibit mild physical impairments related to her weight. However she is very capable at managing her own health related care. She requires no assistance with ADLS or IADLS. She schedules her doctor[']s appointments and transports herself to these appointments.

7. On August 11, 2015, CARES' physician consultant signed off on DOEA's 'Notification of Level of Care' form, indicating that Petitioner did not meet LOC Criteria, and was thus not recommended for any program or specified placement.

8. CARES subsequently notified United of its LOC determination. Per United, an 834 disenrollment file was received on August 14, 2015, with an effective date of August 31, 2015. United processed this file, but did not generate a Notice of Action based upon same. Per post-hearing e-mail correspondence from Christian Laos, Senior Compliance Analyst:

> Unfortunately, our system made an error and a termination letter was never issue[d] for the member, we are investigating the reason for the emission [*sic*] and why the issue was not identify [*sic*] previously, all findings will be shared.[1]

9. On or about August 14, 2015, AHCA's Health Tracks system generated a Notice to Petitioner, which stated, in pertinent part:

> Thank you for calling the Helpline. You asked to leave your current plan because:
> No longer needs LTC services.
> This change will happen on 9/1/2015…

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[1] No further correspondence was received from United with regard to this error.

> After this change,… [you] will not be able to receive Long-term Care services using Medicaid. You can also choose to join another plan for Medicaid Long-term Care services, but will have to go through the long-term care approval process again.

10. Petitioner recalls receiving a Notice that stated she "opted out" of services, but denies that she, herself, elected to stop receiving same.

11. On or about September 2, 2015, Petitioner contacted her (former) case manager with United, and was informed that she was no longer enrolled as a member. Petitioner was unaware of the disenrollment, noted that she would check into the situation, and requested hearing on September 3, 2015, to challenge her resultant loss of services.

12. At hearing, Petitioner explained that she requires assistance to clean her house and to cook, as she is unable to stand or walk for long periods of time. She can use a microwave, but due to [redacted], she is unable to prepare meals on the stove or to perform housekeeping. She had been receiving homemaking services and home-delivered meals from United, but these services stopped once she was disenrolled from the plan. She now has a friend who assists her with shopping, but she would like further assistance in meeting her needs. Petitioner expressed that she did understand why she met the LOC previously, and qualified for LTC services in the past, but was then deemed ineligible while her living and health situation remained the same.

13. Susan Hanley, Program Operations Administrator with CARES, explained that before Medicaid transitioned to managed care in March of 2014 (and rolled over recipients of fee-for-service Medicaid to managed care in May of 2014), recipients were qualified for LTC-like services via eligibility for the Aged and Disabled Adult Waiver. At

that time, CARES reviewed and relied upon assessments completed by (in Petitioner's case) Marion County Senior Services. Marion County reported that Petitioner utilizes medical gas (oxygen) through her [redacted] however, it was later determined that the [redacted] uses only forced room air. Whereas administration of medical gas requires medical oversight, and might qualify a recipient for LTC services, use of a [redacted] [redacted] does not.

14. Ms. Hanley also testified that CARES agrees with Petitioner that she requires assistance with housekeeping, but that this, alone, does not mean she meets LOC, nor does the fact that she can only heat food using a microwave.

15. In comparing Petitioner's needs to the criteria for Intermediate Care Services (Level I and Level II), as contained within Fla. Admin. Code R. 59G-4.180, CARES determined that Petitioner did not meet the overarching criteria of a need for "24-hour observation and care and the constant availability of medical and nursing treatment and care" (*see* 59G-4.180(2)(a)).[2] CARES noted that Petitioner's areas of need are related to instrumental activities of daily living, and are not sufficiently medically complex that without LTC services, Petitioner would require placement in a nursing facility.

16. At hearing, in reviewing the criteria of Fla. Admin. Code R. 59G-4.180, Petitioner noted that she utilizes protective bed sheets for occasional [redacted] which she is unable to change on her own. She self-administers medications, can ambulate short distances, and can complete her own ADLs. However, Petitioner reiterated her need for assistance with meals and housekeeping.

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[2] As this portion of the Rule, defining "Intermediate care nursing home resident," is somewhat confusing, the reader is directed to Fla. Stat. § 409.985 for a clearer explanation of the requirement for constant availability of care.

17. CARES advised Petitioner that as a result of disenrollment, CARES had contacted the Aging and Disability Resources Center (ADRC), requesting that they place Petitioner on a wait list to receive senior services through Community Care for the Elderly (CCE). CARES noted that these services are provided through Elder Options, and suggested that Petitioner follow up to check her status on the wait list, by calling 1-800-963-5337.

18. AHCA confirmed that Petitioner is still eligible for and has continued to receive Medicaid, though now through a Medicaid Managed Care (MMA) plan, instead of LTC.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This Order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

20. This proceeding is a *de novo* proceeding, pursuant to Fla. Admin. Code R. 65-2.056.

21. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to Respondent, who, through CARES, has disenrolled Petitioner from LTC coverage (*See, e.g.*, Fla. Stat. § 409.978 and § 409.985, delegating certain LTC duties to the Department of Elder Affairs and CARES).

22. In accordance with 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 Channeling Services Waiver for Frail Elders.
> …

23. Petitioner transitioned to LTC services on or about May 1, 2014. She maintained these services for at least one year following said transition, but was then re-evaluated by CARES.

24. Per Fla. Stat. § 409.985 (Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program):

> (3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:
>
> (a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
>
> (b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant

> availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
>
> (c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

25. These levels of care correspond to the provisions of Fla. Admin. Code R. 59G-4.290 for “Skilled Services” (daily needs, medically complex), 59G-4.180(4)(a) “Intermediate Care Services Level I” (daily or intermittent, extensive health needs due to physical incapacitation), and 59G-4.180(4)(c) “Intermediate Care Services Level II” (limited needs, due to mild physical incapacitation), respectively.

26. Based upon her 701B Assessment and testimony at hearing, Petitioner does not require the type of skilled services contemplated by Fla. Admin. Code R. 59G-4.290. However, to determine if she qualifies for Intermediate Care Services, review of 59G-4.180 is required.

27. Level I Services are defined in Fla. Admin. Code R. 59G-4.180(4) as:

> (a) Intermediate Care Service Level I is extensive health related care and service required by an individual who is incapacitated mentally or physically.
> (b) Examples of services that qualify as Intermediate Care Services Level I:
> 1. Administration of routine or stabilized dosages of oral medication, eye drops or ointments;
> 2. Routine administration of intramuscular or subcutaneous medication and observation of the individual’s response and side effects;
> 3. Administration and adjustment of medication for pain and the monitoring of results and side effects;
> 4. Routine administration of insulin to a diabetic resident whose condition is stable, but who is unable to self-administer due to physical, mental or medical reasons;

5. Routine oral suctioning;
6. Tracheostomy care when the individual's condition is stable, but the individual is unable to care for the tracheostomy due to physical, mental or medical reasons;
7. Routine intermittent positive pressure breathing (IPPB) therapy after a regimen of therapy has been established or therapy is performed by the resident with nursing supervision;
8. Routine care of stoma and surrounding skin in the presence of colostomy, gastrostomy or ileostomy, excluding the initial period of training, teaching or intensive care, and special problems, for example, bleeding, severe diarrhea, or stricture;
9. Routine care of a supra-pubic catheter, excluding special care in cases of hemorrhage, frequent obstruction, frequent changes;
10. Routine services to maintain satisfactory functioning of indwelling bladder catheters, including routine insertion of catheter and, excluding special care in cases of infection, hemorrhage, frequent obstruction, frequent changes of the catheter, irrigations more than two times daily, or the use of special medications for irrigation and instillation;
11. Changes of dressings, sterile or aseptic, for noninfected postoperative or chronic conditions;
12. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor and noninfected skin problems;
13. Routine care of the incontinent resident, including the use of diapers and protective sheets;
14. General maintenance care in connection with a plaster cast;
15. Routine care in connection with temporary casts, splints, braces or similar devices, excluding observing for circulatory or skin changes in unstable cases;
16. Decubitus care involving superficial, noninfected lesions and preventive measures when a resident is susceptible to decubitic formation;
17. Bowel and bladder control training and maintenance after a successful program has been established;
18. Care of a resident with an amputation or a fracture requiring routine care of a stabilized condition and reinforcement of an established rehabilitation plan;
19. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator, including the use of special baths with whirl-type action when not required to be performed by a physical therapist or licensed nurse;
20. Routine administration of medical gases after a regimen of therapy has been established by a physician and is administered by the resident;
21. Assistance or supervision in dressing, eating and toileting;
22. Periodic positioning or repositioning;
23. General supervision of exercises which have been taught to the resident, including the carrying out of a maintenance program, for example, the performance of repetitive exercises required to maintain functions in paralyzed extremities, assisted walking, and similar procedures;
24. Administration of oxygen on an emergency or short-term basis;
25. Rehabilitative restorative care, passive range of motion (ROM) exercise;

> 26. Routine use of physical restraints or protective devices; and
> 27. Routine dietary management.
>
> (emphasis added to highlight pertinent criteria within the rule).

28. Per Respondent, Petitioner previously qualified for LTC services as a result of an assessment that noted she required the use of medical gasses/oxygen, administered through her This notation was later discovered to be erroneous, as Petitioner uses her only to obtain forced-air to address

29. Although Petitioner does experience occasional she does not require the overarching "constant" availability of medical care or 24-hour observation for incontinence, as needed to qualify for Intermediate Care Level I services under Florida Statute. Indeed, such Level I services require "routine" care of incontinence, and Fla. Admin. Code R. 59G-4.180(2)(c) defines "routine" as "… in accordance with an established or predetermined schedule and performed for individuals whose medical needs are stabilized or chronic." Petitioner is not on an established schedule for incontinent care.

30. Fla. Admin. Code R. 59G-4.180(4) also sets forth service examples for Level II Care, noting:

> (c) Intermediate Care Services Level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:
>
> 1. Be ambulatory, with or without assistive devices,
> 2. Demonstrate independence in activities of daily living, and
> 3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.
>
> (d) Examples of services, in addition to medical supervision, that qualify as intermediate care Level II:
>
> 1. Administration of routine oral medication;
> 2. Assistance with mobilization, helping a resident maintain balance when transferring from bed to chair and providing necessary help when climbing steps or

manipulating wheelchair in difficult places;

3. Assistance with bathing, that is, assembling towels, soap, and other necessary supplies, helping the recipient in and out of the bathtub or shower, turning the water on and off, adjusting water temperature, washing and drying portions of the body which are difficult for the recipient to reach and being available while the recipient is bathing himself;

4. Assistance with dressing, that is, helping the recipient to choose and to put on appropriate clean clothing, and fastening hooks, buttons, zippers and ties;

5. Assistance with meals, that is, helping with cutting up food and pouring beverages;

6. Assistance with grooming, that is, helping the recipient to shave, wash, comb and curl hair, and to clean and file fingernails and toenails. Fingernails or toenails should not be cut by the recipient unless approved by the physician;

7. Provision of social and leisure services which are arranged for and individually designed to reduce isolation and withdrawal and to enhance communication and social skills;

8. Self-administration of medical gases, oral medications, subcutaneous medication after a regimen of therapy has been established and self-administration approved by the physician;

9. Ongoing medical and social evaluations to determine the point when a recipient's progress has reached the stage at which medical and related needs can be met appropriately outside of the nursing facility or through alternative placement or services;

10. Application of dressings and treatments prescribed by the physician for small or superficial areas requiring a dressing;

11. Application of elastic stockings, when prescribed, if the recipient cannot manage independently;

12. Administration of oxygen or intermittent positive pressure breathing when prescribed by the physician and performed by the recipient;

13. Assistance with colostomy care, that is, helping the recipient care for permanent colostomy which the recipient ordinarily cares for;

14. Routine measurement and recording of vital signs and weights, including being alert to symptoms and readings corresponding to abnormal conditions of the residents;

15. Routine restorative and rehabilitation procedures, that is, the encouragement and incorporation of range of motion exercises in the daily activities schedule.
(emphasis added to highlight pertinent criteria within the rule).

31. Again, although initially thought to utilize medical gasses, Petitioner has since been found to utilize a regular [redacted]. In terms of meal preparation, Petitioner does not require the detail-focused assistance of cutting up food or pouring beverages,

and is able to cook for herself using a microwave. Most importantly, the assistance she does require for housekeeping and chores is not “in addition to medical supervision,” (Fla. Admin. Code R. 59G-4.180(4)(d)) but rather, solely for completion of instrumental activities of daily living. As such, these needs do not correspond to the broader Florida Staute requirements of LTC services, i.e., 24-hour observation or constant medical care.

32. It is understood that Petitioner requires assistance around her home, and that she may benefit from home delivered meals and/or services designed to foster community inclusion; however, absent an underlying, constant need for medical care, these needs do not make her eligibile to receive LTC services.

33. Respondent has met its burden to show that disenrollment/termination from LTC was proper.

34. Petitioner is encouraged to contact Elder Options, as well as to pursue services through her MMA plan and/or to seek out the availability of Medicare benefits. Should Petitioner feel that she requires LTC services in the future, she may contact the Department of Children and Families (DCF), AHCA, DOEA, or the Aging and Disability Resources Center for assistance in determining eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner’s 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 04 day of February, 2016,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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