STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

[redacted]	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 08-6157APD
	)	
AGENCY FOR PERSONS WITH DISABILITIES,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

On February 27, 2009, a hearing was held by means of video teleconferencing in [redacted], Florida, before Administrative Law Judge Lisa Shearer Nelson of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Cynthia A. Mikos, Esquire
Allen Dell, P.A.
202 South Rome Avenue
Tampa, Florida 33606

For Respondent: Carrol Y. Cherry, Esquire
Office of the Attorney General
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STATEMENT OF THE ISSUE

The issue to be determined is whether Petitioner's assignment to the Tier 2 Waiver for services pursuant to Section 393.0661, Florida Statutes (2008), is appropriate?

PRELIMINARY STATEMENT

On September 2, 2008, Respondent, Agency for Persons with Disabilities, notified Petitioner that [redacted] was assigned to Tier 2 under the newly implemented tier system mandated by Section 393.0661, Florida Statutes. On September 15, 2008, Petitioner filed a Petition for Administrative Hearing Involving Material Disputed Issues of Fact, and on December 9, 2008, the request for hearing was forwarded to the Division of Administrative Hearings for assignment of an administrative law judge.

The case was assigned to the undersigned and noticed for hearing to be conducted February 27, 2009. On February 23, 2009, Respondent filed a Motion in Limine seeking to exclude any evidence related to medical necessity. Petitioner then filed a response to the Motion in Limine as well as an Emergency Motion for Continuance, based upon the significant impact granting the Motion in Limine would have on the presentation of Petitioner's case. On February 26, 2009, an Order was entered denying both the Motion in Limine and the Emergency Motion for Continuance, and the case proceeded to hearing as scheduled.

Both parties sought official recognition of certain statutes and rules, without objection, and at the commencement of the hearing, official recognition was taken of the following: 1) 42 U.S.C. § 1396; 2) 42 C.F.R. Part 431, Subpart E; 3) 42 C.F.R. Part 441 Subpart G; 4) Chapter 120, Florida Statutes; 5) Sections 393.062, 393.063, 393.064, 393.065, 393.0651, 393.066, 393.125,

393.13, 409.901, and 409.906, Florida Statutes; 6) Florida Administrative Code Rules 59G-1.001-1.010; 59G-13.080-13.083; 65-2, Part VI; 65G-4.0021-4.0025; and 7) The Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, October 2003, updated June 2007, as incorporated by reference in Florida Administrative Code 59G-13.001.

Because through the tier assignment Respondent is seeking to change the provision of services, the parties agreed that Respondent bore the burden of proof in these proceedings. Respondent presented the testimony of Marcia Ulmer and Renee´ Johnson, and Respondent's Exhibits 1-3 and 5-7 were admitted into evidence. Petitioner presented the testimony of Christa Reedy, Valencia Banks, Cynthia Perry, Joseph DeLuca, and Carolyn Smith, and Petitioner's Exhibits numbered 1-18 were admitted into evidence.

At the close of evidence, both parties requested additional time for preparation of proposed recommended orders, and it was agreed that the parties' submissions would be due thirty days from the filing of the Transcript. The Transcript was filed with the Division March 18, 2009, and both parties timely filed Proposed Recommended Orders. Simultaneous with the filing of the Proposed Recommended Orders, Petitioner filed a Motion for Judicial Recognition, asking that official recognition be taken of the Respondent's Answer Brief in Geraud Moreland v. Agency for

_____, Case No. 1D08-4353, pending in the First District Court of Appeal. The undersigned notes that the request for judicial recognition was not filed during the hearing and at the time the proposed recommended orders were submitted, the record was closed. Accordingly, official recognition at this late juncture would not allow the Agency to take the statements in the answer brief into account in preparing its Proposed Recommended Order. The Motion is therefore denied. Compare, Craig v. Craig, 982 So. 2d 724 (Fla. 1st DCA 2008).

All references to the Florida Statutes are to the 2008 codification unless otherwise indicated.

FINDINGS OF FACT

1. Petitioner is a 43-year-old developmentally disabled adult who lives in a group home in [redacted]. Prior to [redacted] current placement, [redacted] resided in institutional settings.

2. Petitioner qualifies to receive services from the Developmentally Disabled Home and Community Based Medicaid Waiver by virtue of [redacted] diagnoses of cerebral palsy and moderate mental retardation. [redacted] also suffers from severe spastic quadriplegia, multiple contractures of all extremities, scoliosis with spinal fusion, seizures, chronic constipation, [redacted], a chronic dislocated right hip, a cardiac condition requiring pacemaker placement, and gingival hyperplasia.

3. [redacted]. is wheelchair bound, unable to sit unassisted, and requires two people to transfer [redacted] from one position to another. Most of [redacted] transfers involve the use of a hydraulic lift. Petitioner is totally dependent on others to assist [redacted] with all of the daily activities of living, and has limited mobility, i.e., some head control and functional movement in one arm.

4. In order to be eligible for waiver services, Petitioner must qualify for Medicaid and must meet the level of care criteria for placement in an intermediate care facility for the developmentally disabled. The waiver is a payor of last resort: in other words, it comes into play after all other methods of payment have been exhausted.

5. The amount, duration, and scope of the services Petitioner may receive are described in the Medicaid Developmental Disabilities Waiver Services Coverage Handbook (Handbook). The services are requested on an annual basis by means of a support plan and are reviewed through a prior service authorization process. If the services are determined to be medically necessary, then they are included in a cost plan.

6. A cost plan is a document that lists all approved waiver services requested by a client and the allocated cost for each waiver service. The cost plan must be approved by the Agency before a client may receive services in any given year. It does not, however, include information such as a client's diagnosis, ability to ambulate or other functional limitations.

7. For the period of July 1, 2008, through June 30, 2009, Petitioner's approved services included in [redacted] cost plan were as follows: 1) waiver support services, in the amount of $1,571.40; 2) adult day training in the amount of $12,292.82; 3) transportation to and from adult day training, in the amount of $6,047.70; 4) standard residential habilitation services in the amount of $42,181.00, and 5) consumable medical supplies in the amount of $5,436.00. The total of the services approved as medically necessary for Petitioner in the 2008-2009 year is $66,528.92.

8. The amount allocated for residential rehabilitation is considered "moderate." The amount allocated is a reduction from the prior year.

9. In 2007, the Legislature amended Section 393.0661, Florida Statutes (the Tier Statute), related to the services available under the Medicaid Waiver programs. The amendments to Section 393.0661 provide certain criteria for placement and established four "tiers" with established annual spending caps for each tier: Tier 1 has no spending limit; Tier 2 has a spending cap of $55,000 per year; Tier 3 has spending cap of $35,000 per year; and Tier 4 is limited to $14,792 per year.

10. The Agency adopted Florida Administrative Code Rules 65G-4.0021, 65G-4.0022, 65G-4.0023, 65G-4.0024 and 65G-4.0025 (the Tier Rules) to implement the Tier Statute. The validity of the rules was challenged in Moreland v. Agency for Persons with

_____, 08-2199RP (DOAH August 6, 2008), in which it was determined that the rules were not invalid exercises of legislatively delegated authority. An appeal of the Moreland order is presently pending in the First District Court of Appeal docketed as First District Case No. 1D08-4353. In the meantime, the Tier Rules became effective October 20, 2008.

11. Florida Administrative Code Rule 65G-4.0021 identifies the factors that must be considered by the Agency in assigning individual clients to tiers. The Agency must consider the client's level of need in functional, medical, and behavioral areas, as determined through the Agency's evaluation of client characteristics, the Agency's approved assessment process, and support planning information; the client's service needs as determined through the Agency's prior service authorization process to be medically necessary; the client's age and current living setting; and the availability of supports and services from other sources.

12. The initial determination of the appropriate tier for a client was determined by use of a computer program, although exactly what data was used to formulate the initial placement was unclear, beyond the fact that the cost of approved services reflected in the 2008-2009 cost plan was used. Once that initial determination was made, it was sent to the local Agency office to determine if the computer-generated assignment was correct. The computer-generated assignment for Petitioner was to Tier 2.

13. The computer-generated assignment was "validated" by reviewing the cost plan and a checklist referred to as the "operational detail checklist." The original version of this operational detail checklist was three pages long. It was condensed to a one-page checklist that included certain criteria taken from the Tier Rules. The operational detail checklist includes references to certain "core" services that are referenced in the tier rules. "Core" or "trigger" services are not defined in any rule or statute.

14. No one could identify who made Petitioner's initial tier assignment or when that assignment was made. The staff members responsible for verifying Petitioner's placement in the field and approving the placement in Tallahassee did not review anything other than the cost plan and the operational detail checklist.

15. While an Individual Cost Guidelines (ICG), an assessment tool identified as a valid assessment tool, was completed for Petitioner on September 11, 2006, the ICG was not used in the preparation of the support plan and therefore not considered in the cost plan for 2007-2008 or 2008-2009.

16. The ICG was not considered in assigning Petitioner to Tier 2.

17. The support plan itself was not considered in assigning Petitioner to Tier 2.

18. The Petitioner's service needs as determined through the prior service authorization process to be medically necessary were not considered in the assignment to Tier 2, except to the extent that the cost plan revealed that Petitioner was approved to receive residential habilitation services. Most importantly, there was no consideration of how the approved services worked together to meet Petitioner's needs.

19. Petitioner's need for adult day services, transportation, consumable medical supplies and support coordination were not considered in the tier assignment process.

20. Agency staff did not actually consult the Tier Rules or the statute in actually making the tier determination for Petitioner. There is no evidence that staff considered whether Petitioner's needs for medical or adaptive services could be met in Tier 2.

21. In reality, however, Petitioner's approved services are designed to work together to provide a cohesive plan for Petitioner's care.

22. According to the current Handbook, the moderate level of residential habilitation, which is the level for which Petitioner is approved, requires the residential provider to maintain a staffing level at the group home of six hours per day of direct care staff time devoted to training, intervening and supervising group home residents. The group home where Petitioner resides does not staff the group home during the day

when residents are scheduled to attend adult day training. When a resident has to stay in the home and not attend adult day training as a result of illness, for example, management staff stays with the resident to provide for his or care. This arrangement, however, is not intended to provide care on a regular, ongoing basis.

23. Petitioner's assignment to Tier 2 results in an annual cap of $55,000. This cap results in a reduction of approximately $12,400 of available funds annually to pay for waiver services. Residential habilitation and support coordination alone amount to $43,752.40.

24. Under any scenario available to Petitioner, in order to reduce [redacted] services in order to fit within the "cap" identified, [redacted] would be required to reduce [redacted] adult day training program and the transportation to and from the program. Reduction of adult day training services would require [redacted] residential habilitation provider to refer [redacted] to another, more institutionalized, placement.

25. Based on the evidence as a whole, placing Petitioner in Tier 2 would not meet [redacted] needs in terms of medical or adaptive services and will in all likelihood result in [redacted] institutionalization.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties to this

action in accordance with Sections 120.569 and 120.57(1), Florida Statutes.

27. In administrative hearings, the burden of proof is on the party asserting the affirmative of an issue. Wilson v. Department of Administration, Division of Retirement, 538 So. 2d 139, 141-2 (Fla. 4th DCA 1989); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). The Agency bears the burden of proof in this de novo proceeding to demonstrate by a preponderance of the evidence that M.D. is appropriately placed in the Tier Two waiver. § 120.57(1)(j), Fla. Stat.

28. Section 393.0661, Florida Statutes, defines the tiers for service delivery related to developmental disabilities and the process to be used as follows:

> (3) The Agency for Health Care Administration, in consultation with the Agency, shall seek federal approval and implement a four-tiered waiver system to serve clients with developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods. All services covered under the current developmental disabilities waiver shall be available to all clients in all tiers where appropriate, except as otherwise provided in this subsection or in the General Appropriations Act.
>
> (a) Tier one shall be limited to clients who have service needs that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for

> avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk or harm to themselves or others.
>
> (b) Tier two shall be limited to clients whose service needs include a licensed residential facility and who are authorized to receive a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services or clients in supported living who receive greater than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $55,000 per client per year.
>
> (c) Tier three shall include, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who live in their family home. Total annual expenditures under tier three may not exceed $35,000 per client per year.
>
> (d) Tier four is the family and supported living waiver. Tier four shall include, but is not limited to, clients in independent or supported living situations and clients who live in their family home. . . . . Total annual expenditures under tier four may not exceed $14,792 per client per year. (Emphasis supplied.)

29. Florida Administrative Code Rule 65G-4.0021 provides in pertinent part:

> (1) The Agency for Persons with Disabilities will assign clients of home and community-based waiver services for persons with developmental disabilities to one of the four Tier Waivers created by Section 393.0661, F.S. (2007). The Agency will determine the Tier Waiver for which the client is eligible and assign the client to that waiver based on the developmental disabilities waiver criteria and limitations contained in the following provisions: Sections 409.906(13)

and 393.0661, F.S.; and Rule 59G-13.080, F.A.C.:

(a) The client's level of need in functional, medical, and behavioral areas, as determined through Agency evaluation of client characteristics, the Agency approved assessment process, and support planning information;

(b) The client's service needs as determined through the Agency's prior service authorization process to be medically necessary;

(c) The client's age and current living setting; and

(d) The availability of supports and services from other sources, including natural and community supports.

* * *

(3) For all Tiers client [sic] must utilize all available State Plan Medicaid services including, but not limited to, personal care assistance, therapies, and medical services, that duplicate the waiver services proposed for the client. A client shall not be provided waiver services that duplicate available State Plan Medicaid Services including, but not limited to, personal care assistance, therapies, and medical services.

(4) The Agency will review a client's tier eligibility when a client has a significant change in circumstances or condition that impacts on the client's health, safety, or welfare or when a change in the client's plan of care is required to avoid institutionalization. The information identifying and documenting a significant change in circumstances or condition that necessitates additional or different services must be submitted by the client's Waiver Support Coordinator to the appropriate Agency Area office for determination. (Emphasis supplied.)

30. Tier One is limited to those clients whose needs for medical and adaptive services cannot be met in any of the other tiers and are essential for avoiding institutionalization, or where the client possesses behavioral problems that are exceptional in intensity, duration, or frequency with resulting service needs that cannot be met in the other tiers and the client presents a substantial risk of harm to themselves or others. Fla. Admin. Code R. 65G-4.0022(1).

31. Tier Two is limited to clients whose service needs include placement in a licensed residential facility and authorization for greater than five hours of residential habilitation services each day, or where the client is in supported living and is authorized to receive more than six hours each day of in-home support services. Fla. Admin. Code R. 65G-4.0023.

32. Rule 65G-4.0021 requires that the Agency consider the client's level of need in functional, medical, and behavioral areas, as determined through Agency evaluation of client characteristics, the Agency-approved assessment process and support planning information; the client's service needs as determined through the prior service authorization process to be medically necessary; the client's age and current living setting; and the availability of supports and services from other sources. The Agency clearly did not meet its obligation in this regard.

It considered only the cost plan, the current living setting, and the number of residential habilitation hours currently approved. Agency personnel testified that no documents other than the cost plan and the "operational detail checklist" were consulted in making Petitioner's tier assignment. No reference was made to the needs assessment completed for Petitioner; to the Petitioner's support plan; or to what available supports and services are or are not available from other sources.

33. The Agency took the position at hearing that only the cost plan was really relevant because information in the support plan was already considered in the prior service authorization process and thus considered in the development of the cost plan. However, Rule 65G-4.0021 clearly requires the Agency to consider the client's level of need in functional, medical and behavioral areas, and specifically references use of support planning information and the assessment process. The cost plan, standing alone, simply does not paint a picture of what a client needs to avoid institutionalization. It simply identifies what services have been approved and the costs allocated for those services.

34. The Agency was required to show not only that it considered the appropriate information in making the tier assignment, but that it also considered whether the proposed assignment could meet Petitioner's needs and avoid institutionalization, and that its placement was appropriate. Here, no such showing was made. To the contrary, the greater

weight of the evidence indicates that, based on the information contained in Petitioner's support plan, and the services approved as medically necessary, reduction of those services will in fact lead to institutionalization for Petitioner.

RECOMMENDATION

Upon consideration of the facts found and conclusions of law reached, it is

RECOMMENDED:

That a final order be entered assigning Petitioner to Tier 1.

DONE AND ENTERED this 15th day of May, 2009, in Tallahassee, Leon County, Florida.

S

LISA SHEARER NELSON
Administrative Law Judge
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Filed with the Clerk of the
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COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.