Third District Court of Appeal

State of Florida

Opinion filed March 18, 2020.
Not final until disposition of timely filed motion for rehearing.

No. 3D19-1702
Lower Tribunal Nos. AHCA: 19-FH0681 & AHCA: 19-FH0692

D.R.,
Appellant,

vs.

United Healthcare of Florida, Inc.,
Appellee.

An appeal from the State of Florida, Agency for Health Care Administration.

Legal Services of Greater Miami, Inc., and Miriam Haskell, and Jeffrey M. Hearne, for appellant.

Parker, Hudson, Rainer & Dobbs LLP, and Kristen Bond, Seann M. Frazier, and Marc Ito (Tallahassee), for appellee.

Before SALTER, FERNANDEZ, and MILLER, JJ.

MILLER, J.

Appellant, D.R., challenges a final agency decision upholding the reduction in home health care services administered to her by appellee, United Healthcare of Florida, Inc. ("United Healthcare") pursuant to Florida Medicaid. We reverse and remand for further proceedings.

United Healthcare, a managed care plan, contracts with the Agency for Health Care Administration to fund and coordinate care for enrolled Medicaid recipients. See §§ 409.966-.967, Fla. Stat. (2019). In the fall of 2018, D.R. suffered a debilitating cerebrovascular accident and was admitted to an inpatient rehabilitation facility. Upon her release, D.R. sought "at home" services under the Statewide Medicaid Managed Care Long-Term Care Program, tasked with "the avoidance or mitigation of 'institutionalization'" of eligible recipients. M.B. v. Agency for Persons with Disabilities, 13 So. 3d 509, 512 (Fla. 3d DCA 2009); Fla. Admin. Code R. 59G-13.080(1). After reviewing D.R.'s needs, United Healthcare authorized forty-five hours per week of combined personal care support and homemaker services.

Less than two months after care commenced, United Healthcare orally informed D.R. of its intent to reduce the approved hours.[1] Thereafter, D.R. requested

[1] Under 42 C.F.R. § 435.917, "any decision affecting . . . eligibility" for benefits must be communicated in writing. See 42 C.F.R. § 435.917(a) ("[T]he agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice

and received a Medicaid Fair Hearing. See Fla. Admin. Code R. 59G-1.100(2)(j); § 409.285(2), Fla. Stat. (2019). At the hearing, the presiding officer placed the burden of establishing by a preponderance of the evidence the continued necessity of the previously allotted hours upon D.R.

The burden of proof in adverse benefit determination proceedings is codified in Rule 59G-1.100(17)(g) of the Florida Administrative Code. It provides, in relevant part, such burden rests "on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service." Fla. Admin. Code R. 59G-1.100(17)(g).

Here, the dispute arose as the result of a "suspension, reduction, or termination" of formerly authorized services.[2] Thus, United Healthcare bore "the burden of proving by a preponderance of the evidence that these three categories of services, though previously provided, should be reduced or eliminated." M.B., 13 So. 3d at 511. Accordingly, as the burden was improperly shifted, we reverse and remand for further proceedings.

Reversed and remanded.

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must – (1) Be written in plain language; (2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b), and (3) If provided in electronic format, comply with § 435.918(b).").

[2] United Healthcare argues the earlier authorization was "temporary" in nature. The relevant code provision does not distinguish between temporary and permanent services. Thus, we decline to import such a distinction. In any event, the record is devoid of any prelitigation evidence supporting this characterization.