



FILED

Jan 07, 2021, 1:11 pm
OFFICE OF FAIR HEARINGS

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS**

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PETITIONER,

AHCA Case No.: 20-FH █

vs.

**SIMPLY HEALTH CARE PLANS, INC. d/b/a
CLEAR HEALTH ALLIANCE,**

RESPONDENT.

_____ /

█

PETITIONER,

AHCA Case No.: 20-FH █

vs.

**SIMPLY HEALTH CARE PLANS, INC. d/b/a
CLEAR HEALTH ALLIANCE,**

RESPONDENT.

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vs.

**SIMPLY HEALTH CARE PLANS, INC. d/b/a
CLEAR HEALTH ALLIANCE,**

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic consolidated Fair Hearing in the above styled case on December 8, 2020, at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner

For the Respondent: Angela Royster
Grievance and Appeals Coordinator
Simply Healthcare Plans, Inc. d/b/a
Clear Health Alliance

STATEMENT OF ISSUE

The first issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of fourteen (14) hours per week of Personal Care services was correct.

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of six (6) hours per week of Homemaker services was correct.

The third issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of ten (10) hours per week of Adult Companion Care services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the Fair Hearing telephonically. Petitioner appeared for the Fair Hearing to provide testimony and did not call any witnesses. Angela Royster, Grievance and Appeals Coordinator for Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance ("Simply Healthcare"), appeared for the Fair Hearing as a representative for Respondent. The following persons appeared for the Fair Hearing as witnesses for the Respondent: Roberta

Frank, Nurse Appeals Associate for Simply Healthcare; and Dr. Marc Kaprow (“Dr. Kaprow”), Doctor of Osteopathic Medicine and Medical Director for Simply Healthcare. Lisa Sanchez, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as an observer.

Petitioner introduced an evidence packet containing five (5) pages, which was admitted into evidence as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 included the following: an e mail from Petitioner (dated November 4, 2020); three letters from Petitioner (dated November 3, 2020); and a facsimile transmission document (dated June 26, 2020).

Petitioner introduced an evidence packet containing fifteen (15) pages, which was admitted into evidence as Petitioner’s Composite Exhibit 2. Petitioner’s Composite Exhibit 1 included the following: an e mail from Petitioner (dated November 30, 2020); a letter from Petitioner (dated November 30, 2020); and Appendix K: Emergency Preparedness and Response and COVID 19 Addendum (dated April 8, 2020).

Respondent introduced a letter (dated November 3, 2020), which was admitted into evidence as Respondent’s Exhibit 1.

Respondent introduced an e mail (dated November 3, 2020), which was admitted into evidence as Respondent’s Exhibit 2.

Respondent introduced an evidence packet containing two hundred and sixty two (262) pages, which was admitted into evidence as Respondent’s Composite Exhibit 3. Respondent’s Composite Exhibit 3 included the following: a Table of Contents; a Sequence of Events; a LTC Service Request Form (dated June 17, 2020); a Comprehensive Plan of Care (signed on January 14, 2020); a Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B

Assessment”) (dated May 13, 2020); Respondent’s communication logs; Prior Authorization Notes (Authorization Number: [REDACTED]); a Notice of Adverse Benefit Determination (“NABD”) (dated June 18, 2020) (Plan ID: [REDACTED]); a letter from Petitioner (dated June 26, 2020); a letter from [REDACTED] (“[REDACTED]”) (dated June 25, 2020); a facsimile transmission document (dated June 26, 2020); Respondent’s fax cover sheet (dated June 26, 2020); a copy of the letter from Petitioner (dated June 26, 2020); a copy of the letter from [REDACTED] (dated June 25, 2020); a Provider Complaint Acknowledgement letter (dated June 26, 2020); an LTC Review and Recommendation (dated July 6, 2020); a Provider Complaint Resolution (dated July 7, 2020); Provider Appeal Notes (Provider Appeal Case Number: [REDACTED]); Quarterly Visit notes (dated July 10, 2020); Petitioner’s Advanced Directives; Natural Disaster Plan (dated July 10, 2020); Member Centric Goals (dated July 10, 2020); a Comprehensive Plan Of Care (signed on January 14, 2020); a Plan of Care Summary (signed on January 14, 2020); Monthly Contact records (dated August 21, 2020); a 701B Assessment (dated August 21, 2020); Face to Face Visit records (dated September 25, 2020); a LTSS Fall Risk Assessment (dated September 25, 2020); a Caregiver Assessment (dated September 25, 2020); Natural Disaster Plan (dated September 25, 2020); a Comprehensive Plan Of Care (signed on January 14, 2020); a Plan of Care Summary (signed on January 14, 2020); a Grievance Acknowledgement letter (dated October 2, 2020); a Continuation of Benefits Denial Notice (dated October 15, 2020); a Grievance Resolution letter (dated October 19, 2020); Member Grievance Notes (Member Grievance#: [REDACTED]); Monthly Contact records (dated November 3, 2020); a fax email (dated November 4, 2020); three letters from Petitioner (dated November 3, 2020); a fax transmission document (dated June 26, 2020); an email from Provider ([REDACTED]) (dated February 10, 2020); the Florida Medicaid

Statewide Medicaid Managed Care Long term Care Program Coverage Policy (“LTC Policy”) (March 2017); and a Simply Healthcare Provider Manual.

FINDINGS OF FACT

1. As of [REDACTED] 2019, Petitioner is an enrolled member of Simply Healthcare’s Long Term Care (“LTC”) Program. See Respondent’s Composite Exhibit 3, page 9. Simply Healthcare is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.

2. Petitioner is sixty nine (69) years old and lives in the community with his wife. *Id.* at 13 14. Petitioner experiences the following health conditions: acid reflux/GERD; arthritis; high blood pressure; high cholesterol; constant dizziness; asthma; osteoporosis; sleep apnea; history of falls; and prostrate (bph). *Id.* at 19 20. Petitioner is diagnosed with Depression and takes medication for his mental health. *Id.* at 22. Petitioner has no recent falls, emergency room visits, hospitalizations, no changes in condition, and no changes in medication. *Id.* at 36. Petitioner is showing symptoms of Parkinson’s Disease and awaiting knee replacement surgery. *Id.* at 45. [REDACTED]

[REDACTED] recommended that Petitioner continue receiving the services at issue. *Id.* Respondent’s Prior Authorization Notes states as follows:

6 17 2020 ON 6/17/20 HOURS SUBMITTED FOR REVIEW:
T1019CG PC 14 HRS/WK
S5130CG HMK 6 HRS/WK
S5135CG COMP CARE 10 HRS/WK

Member is a 69 y/o male who lives with wife(CG). Member ambulates with a cane however need assistance with all adl's. Member suffers from sleep apnea, frequent fall, BPH, depression, Gerd, OA, HBP, hyperlipidemia, frequent dizziness, asthma, COPD, and osteoporosis. Member is receiving the above. Hours were submitted for review due to a conflict in provider. Member wife is the PDO for member however she is receiving LTC service from another provider.

Member's CG was attempting to have member become DSW providing services that he states unable to do for himself. CM confirmed they are each other CG at this moment. As per srf member states that he and wife assist each other and compensate for any deficits. Member drives the wife and provides companionship and wife assist member to use bathroom at night. Member states right foot has become worse. Member is currently approved HDM 31 unit/mo, PC 14 hr/wk, HMK 6 hr/wk, and COM 10 hr/wk. UM Recommendation is to terminate PC, terminate HMK 6 hr/wk, and terminate COM. Member is able to be the CG to wife which indicates that he is capable of taking care of himself as well as the wife. Member is A & O x 3, has not had a fall since orientation 11/19 as per CM, member is able to drive, has not had any hospitalization within the last year, able to climb two to three steps, and no changes to vision hearing. Hours approved are excessive and not needed. LTC is supplemental care.

UM Recommendation Terminate
Terminate T1019CG PC 14 HRS/WK
Terminate S5130CG HMK 6 HRS/WK
Terminate S5135CG COMP CARE 10 HRS/WK
UM RECOMMENDATION BASED ON THE FLORIDA MEDICAID STATEWIDE
MEDICAID MANAGED CARE LONG TERM CARE PROGRAM COVERAGE POLICY
Sashana Pusey, LPN

Id. at 36.

3. Petitioner's wife, [REDACTED] (" [REDACTED]"), is Petitioner's primary caregiver. *Id.* at 27
28. [REDACTED] does not work outside of the home. *Id.* [REDACTED] is very confident in her ability to continue providing care for Petitioner. *Id.* [REDACTED] does not attend school outside of the home. *Id.* at 127. [REDACTED] is willing to provide same care to Petitioner. *Id.* [REDACTED] is not in crisis. *Id.*

4. Petitioner needs assistance (but not total help) with Activities of Daily Living ("ADLs") such as bathing, dressing, using the bathroom, transferring, and walking/mobility. *Id.* at 17. Petitioner needs no assistance with eating. *Id.* Petitioner always has assistance with ADLs. *Id.* Petitioner's wife assists Petitioner with ADLs. *Id.*

5. Petitioner needs total assistance with Instrumental Activities of Daily Living (“IADLs”) such as heavy chores and light housekeeping. *Id.* at 18. Petitioner needs no assistance with using the telephone, managing money and medication, and using transportation. *Id.* Petitioner needs supervision or prompt with preparing meals and shopping. *Id.* Petitioner always has assistance with IADLs. *Id.* Petitioner’s wife assists Petitioner with IADLs. *Id.*

6. Prior to the instant action, Petitioner received the following services: 31 Home Delivered Meals per month; 14 hours per week of Personal Care services; 6 hours per week of Homemaker services; and 10 hours per week of Adult Companion Care services. *Id.* at 36.

7. On June 18, 2020, Simply Healthcare issued an NABD terminating Petitioner’s Personal Care services, Homemaker services, and Adult Companion Care services. *Id.* at 38 42. The NABD states as follows:

Simply Healthcare Plans, Inc. has reviewed your request for continuation of your T1019CG PERSONAL CARE 14 HOURS PER WEEK, S5130CG HOMEMAKER 6 HOURS PER WEEK, AND S5135CG COMPANION CARE 10 HOURS PER WEEK, which we received on 06/17/2020. After our review, this service has been:

Terminated as of 06/28/2020.

We made our decision because:
(Check all boxes that apply)

- We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (*See Rule*)
 - Meet all of the criteria as defined in Rule 59G 1.010(166), F.A.C., for all nursing facility services and mixed services; OR
 - Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community based services:
 1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and
 2. 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

3. Be furnished in a manner not primarily intended for the taker, or the provider;
- and one of the following:
1. Enable the enrollee to maintain or regain functional capacity; or
 2. Enable an enrollee receiving long term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: We will stop the hours of the homemaker care (TERMINATE: S5130 HOMEMAKER CARE 6 HOURS PER WEEK). We will stop hours of the personal care (TERMINATE: T1019 PERSONAL CARE 14 HOURS PER WEEK). We will stop the companion care (TERMINATE: S5135CG COMPANION CARE 10 HOURS PER WEEK). **You have problems with your health. You are able to care for yourself. You are able to be a caregiver. You are able to drive a car. These hours that you asked are not medically needed at this time.**

This decision was based on the information provided and the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy. A peer to peer reconsideration may be requested by your physician/health care provider within 2 days of the adverse determination. A formal appeal must be filed after this timeframe. To request a peer to peer please call 877 440 3738 extension 106 122 9003.

...

Sincerely,

Jessica Otto, D.O. FACP (also referred to as "Dr. Otto").

...

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Simply. When you ask for a plan appeal, Simply has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request within 60 days of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your Services to Continue" section below for details.) Here is where to call or send your request:

Medical Appeals
Grievance and Appeals Coordinator
Simply Healthcare Plans, Inc.
4200 W. Cypress St., Suite 900
Tampa, FL 33607 4173
PHONE: 1 877 440 3738 (TTY 711)

FAX: 1 866 216 3482

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

Id. at 38 44. (Emphasis added).

8. Respondent's Recommendation notes (dated July 6, 2020) states the following:

Based on the visual assessment [case manager] completed at the time of orientation it appeared member needed the service but members wife is available to provide the assistance. Simply was later informed that members wife is also an LTC member in a different plan and our member [Petitioner] is the worker. He assist his wife with personal care, homemaking, companion. The other plan stated the wife appears to be needy and our member appears to be able to assisting with all service. Based on this the [case manager] feels member may have misrepresented himself during the face to face visit. The member has been re assessed but telephonically due to Covid 19. Member states he needs the assistance. When asked how it is that he needs the assistance for himself but is able to provide the assistance to his wife he stated they help each other.

[Case manager] has explained that it looks weird that he states he cannot complete ADL's for himself but is able to complete AOL's for his wife. [Member] does not see anything wrong with being each other's direct service worker.

Id. at 54.

9. Simply Healthcare's Provider Manual states the following:

11 MEMBER APPEAL AND GRIEVANCES PROCEDURES

Members have the right to examine the case file, including medical records and any other material to be considered during the process. They may ask for a free copy of the guidelines, records or other information used to make all decisions related to the appeal. The request can be made before, during or after the appeal.

What you should know:

- If coverage of the service you asked for has been denied, limited must ask for an appeal within 60 days of the date on the letter that said we would not pay for the service.

...

The Appeal Process

An appeal may be filed orally or in writing within 60 calendar days of receipt of our [NABD].

There are four ways to submit an appeal:

1. Write us a letter and ask to appeal. You may also use the appeal
2. Call Member Services at 1 877 440 3738 and ask to appeal.
3. E mail us at flmedicaidgrievances@amerigroup.com.
4. **Send a fax to 1-866-216-3482.**

...

Members Rights in the Appeals Process

- We will tell you what the doctor decides withing 30 calendar days of getting your appeal (or 48/72 hours for expedited appeals.)

Id. at 243. (Emphasis added).

10. On July 31, 2020, Petitioner's Authorized Representative timely requested a Fair Hearing to contest the terminations of services. On October 26, 2020, the undersigned issued an Order to Show Cause to Petitioner. The undersigned ordered Petitioner to submit to the Office of Fair Hearings, on or before November 5, 2020, a Notice of Plan Appeal Resolution ("NPAR") or other documentation or explanation to show cause why the request for a Fair Hearing in all three cases should not be dismissed for failure to complete the plan appeal process. The undersigned received two responses from Respondent on November 3, 2020. *See* Respondent's Exhibit 1; *see also* Respondent's Exhibit 2. Respondent stated as follows:

Please consider this an Explanation of Missing Documents related to the request for Medicaid Fair Hearing submitted by the above named member, for Personal

Care Services. As of this date, Simply Healthcare Plans, Inc. has not received a request for an appeal related to this service. Therefore, a Notice of Plan Appeal Resolution letter is not available for submission.

Id.

11. On November 4, 2020, the undersigned received Petitioner's response to the Order to Show Cause. Petitioner's response includes a fax transmission document dated June 26, 2020, and addresses to a Grievance and Appeals Coordinator at 1 866 216 3482. *See* Petitioner's Composite Exhibit 1, page 5; *see also* Respondent's Composite Exhibit 3, page 48. Petitioner's letter to Simply Healthcare's Grievance and Appeals Coordinator states the following, in pertinent part:

We have the honor to appeal to you to kindly reconsider continuation of his T1019CG PERSONAL CARE 14 HOURS PER WEEK, S5130CG HOMEMAKER 6 HOURS PER WEEK, AND S5135CG 10 HOURS PER WEEK, which are extremely vital cares [Petitioner], 69, legally disabled, have been receiving since December 2019 from Simply Healthcare.

See Respondent's Composite Exhibit 1, page 43.

12. With respect to the Order to Show Cause, at the hearing, Petitioner confirmed that this letter was faxed to Respondent on June 26, 2020. Ms. Royster confirmed that Respondent received Petitioner's letter. As testified to by Petitioner, Petitioner faxed the request for a plan appeal. As testified to by Ms. Royster, Respondent interpreted the letter Petitioner referenced as a Complaint (also referred to as a "Grievance"), not a plan appeal. As testified to by Ms. Royster, Respondent processed a Provider Appeal Resolution letter, but argued that this is not the same as an NPAR. Petitioner signed a letter dated June 26, 2020, appealing the termination of Personal Care services, Homemaker services, and Adult Companion Care services. *See*

Respondent's Composite Exhibit 3, page 45. The undersigned scheduled the hearing to be convened by telephone on December 8, 2020, at 9:00 a.m. EST.

13. With respect to the termination of LTC services, at the hearing and under oath, Dr. Kaprow testified that Dr. Jessica Otto made the initial decision to terminate services in June 2020 on behalf of Respondent. Petitioner is enrolled into the Participant Direction Option ("PDO") program where his LTC services are administered through Petitioner's wife, his PDO Direct Service Worker. Respondent was notified through the payroll company assigned to the PDO program that Petitioner's wife is also enrolled into a Florida Medicaid LTC program where she is also enrolled into the PDO program, but has her LTC services were administered through Petitioner, her husband. Respondent determined that if Petitioner can render natural support and LTC services for another person, then he can provide care for himself. Respondent argued that Petitioner's LTC services at issue are no longer needed because he can provide care for himself, as well as others, and has the natural support of his wife to meet his needs.

14. With respect to the termination of LTC services, at the hearing and under oath, Petitioner confirmed that he is enrolled into the PDO program and his wife is his PDO Direct Service Worker. Petitioner confirmed that his wife is also enrolled into the Florida Medicaid program and the PDO program with another Medicaid Managed Care plan. Petitioner testified that as his wife's PDO Direct Service Worker, Petitioner renders seven (7) hours per week of Homemaker services and eleven (11) hours per week of Personal Care services. Petitioner testified that he provides Adult Companion Care services to his wife, but is not compensated for such services because his wife's Medicaid Managed Care plan has not approved such services. Petitioner argued that both him and his wife require care, and they depend on one another for support to meet their daily needs.

Petitioner testified that he and his wife are each other's PDO Direct Service Workers because they are considered "high risk" individuals to the Coronavirus and do not want exposure to other people inside of the home. Petitioner testified that the money earned through the PDO Program is used for living expenses such as food, electricity, clothing, toiletries, and overseas medicine. In closing, Petitioner argued that the undersigned should reinstate the LTC services at issue for his financial need and medical need.

CONCLUSIONS OF LAW

15. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statutes ("Fla. Stat.") § 409.285(2) (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

16. Pursuant to Fla. Admin. Code R. 59G 1.100(17)(b), this hearing was held as a *de novo* proceeding.

17. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G 1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. **The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service.** The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

(Emphasis added).

18. Because Respondent terminated existing services, the burden of proof is on the Respondent. See Fla. Admin. Code R. 59G 1.100(17)(g). The standard of proof in an administrative

hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

Petitioner’s compliance with Fla. Admin. Code R. 59G-1.100(8)(e).

19. The Agency has jurisdiction and must provide a Fair Hearing for an enrollee who makes a hearing request regarding the following:

1. A notice of plan appeal resolution indicating that the plan appeal did not result in the reversal of a prior denial of a new service, or the reduction, suspension, or termination of a previously authorized service, if timely challenged by the enrollee in accordance with the plan appeal procedures following the timely issuance of the plan’s NABD to the enrollee,
2. **The failure of the plan to adhere to notice and timing requirements applicable to plan appeals, or**
3. The failure of the plan to timely notice the enrollee through a NABD, subsequent to the plan’s failure to provide medically necessary services requested by the enrollee to the enrollee with reasonable promptness.

Fla. Admin. Code R. 59G 1.100(3)(b). (Emphasis added).

20. An Enrollee must initiate and complete a plan appeal before making a Fair Hearing request unless the plan appeal was not properly noticed or is untimely. *See* Fla. Admin. Code R. 59G 1.100(8)(e).

21. A Hearing Officer is authorized to deny or dismiss a request for a Fair Hearing if the Enrollee has not completed the plan appeal. *See* Fla. Admin. Code R. 59G 1.100(9)(b)(2).

22. In this case, on June 18, 2020, Simply Healthcare issued an NABD terminating Petitioner’s Personal Care services, Homemaker services, and Adult Companion Care services. *See supra* ¶ 7. Respondent requires that a plan appeal be filed orally or in writing within 60 calendar days of receipt of the NABD. *See supra* ¶ 9. Respondent allows recipients to request a plan appeal via facsimile. *See supra* ¶ 9. On June 26, 2020, Petitioner faxed a letter to Respondent requesting a continuation of the Personal Care services, Homemaker services, and Adult Companion Care

services at issue. See supra ¶ 11. Petitioner's facsimile was sent to the fax number Respondent provided to its members. See supra ¶ 9. Respondent agrees that they received Petitioner's letter, but argues that the letter was a filing of a Complaint/Grievance, not a request for a plan appeal. See supra ¶ 12. Neither Respondent's Provider Manual nor Fla. Admin. Code R. 59G 1.100 mandate specific language that must be used to request a plan appeal. Upon review of Petitioner's letter along with the NABD, the undersigned finds that Petitioner's letter constitutes a request for a plan appeal.

23. Thus, based upon the date of the NABD and the date of the Plan Appeal request, the undersigned also finds that Petitioner's request for a plan appeal was timely and Respondent did not properly process Petitioner's plan appeal. Further, the undersigned finds that Respondent failed to process Petitioner's plan appeal within 30 calendar days of June 26, 2020, the date Petitioner faxed his Plan Appeal request to Respondent. Upon consideration of the both parties evidence and testimony, the undersigned finds that Respondent failed to adhere to notice and timing requirements applicable to plan appeals. In conclusion, the Agency has jurisdiction and must provide a Fair Hearing regarding the NABD terminating Petitioner's Personal Care services, Homemaker services, and Adult Companion Care services.

Respondent's termination of Petitioner's Personal Care services, Homemaker services, and Adult Companion Care services

24. The Florida Medicaid Statewide Medicaid Managed Care Long term Care Program Coverage Policy ("LTC Policy") (March 2017), incorporated by reference in Fla. Admin. Code R. 59G 4.192, establishes the provision and coverage for Long term Care services available under the Florida Medicaid program. See Respondent's Composite Exhibit 3, 187 208. The LTC Policy states as follows:

1.1 Description and Program Goal

Under the Statewide Medicaid Managed Care Long term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community based services that enable enrollees to live in the community and to avoid institutionalization.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual's medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G 1.010, F.A.C.
- b) All other LTC supportive services must meet all of the following:
 - 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
 - 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
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person centered goals, and to live and work in the setting of his or her choice.

1.3.16 Natural Supports

Unpaid supports that are provided voluntarily to the individual in lieu of home and community based services and supports.

...

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the policy.

4.2 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least restrictive setting

...

4.2.1 Home and Community-Based Supportive Services

The LTC program benefit includes coverage of the following home and community based supportive services:

4.2.1.1 Adult Companion Care

The provision of non medical care, supervision when necessary to protect the health, safety, and well being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

4.2.1.8 Home Delivered Meals

The provision of nutritionally sound meals delivered to an enrollee’s home when an enrollee has difficulty shopping for, or preparing food, without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake. The meals must meet the current Dietary Guidelines for Americans, the United States Department of Agriculture My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long term Care benefit includes coverage of the following mixed services:

...

4.2.2.6 Personal Care

In accordance with Rule 59G 4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

Respondent’s Composite Exhibit 3, 187 208.

25. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G 1.010, defines Medical Necessity as:

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- 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
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

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.

26. Based on the NABD, Respondent terminated Petitioner's Personal Care services, Homemaker services, and Adult Companion Care services based on medical necessity. *See supra* ¶ 7. Respondent determined that, "You are able to care for yourself. You are able to be a caregiver. You are able to drive a car" and "these hours that you asked are not medically needed at this time." *See supra* ¶ 7. Respondent also determined that the LTC services at issue are excessive and not needed. *See supra* ¶ 2. Respondent based their medical necessity determination on the LTC Policy. *See supra* ¶ 7. The undersigned considered the recommendation of Petitioner's provider. However, the fact that a provider has recommended services does not, in itself, make such services medically necessary. *See supra* ¶ 25.

27. The LTC Policy covers Personal Care services, Homemaker services, and Adult Companion Care services if they are deemed to be medically necessary. Because Personal Care services are classified as "Mixed Services," Petitioner must meet the medical necessity criteria defined in section 2.83 of the the Definitions Policy. *See supra* ¶ 24. Because Homemaker services and Adult

Companion Care services are classified as “Home and Community Based Supportive Services,” Petitioner must meet the medical necessity criteria defined in section 1.3.14(b) of the the LTC Policy. *See supra* ¶ 24. Based on the record, Respondent terminated Petitioner’s Personal Care services, Homemaker services, and Adult Companion Care services for not meeting the following medical necessity standard: Services must 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. These medical necessity standards are outlined in section 2.83 of the the Definitions Policy and section 1.3.14(b) of the the LTC Policy. *See supra* ¶ 24 25.

28. With respect to the Medical Necessity standard at issue, Respondent determined that Petitioner no longer needs Personal Care services, Homemaker services, and Adult Companion Care services because the record reflect that Petitioner is his wife’s Direct Service Worker and is paid to provide these same services to his wife who is also enrolled into the Florida Medicaid program. *See supra* ¶ 13. Specifically, Respondent argues that Petitioner does not have a need for Personal Care services because Petitioner provides “assistance with ADLs and IADLs” to his wife, is compensated for such services as a Direct Service Worker, and is able to perform these activities for himself. Respondent argues that Petitioner does not have a need for Homemaker services because Petitioner provides assistance with “general household activities and routine household care” to his wife, is compensated for such services as a Direct Service Worker, and is able to perform these activities for himself. Respondent also argues that Petitioner does not have a need for Adult Companion Care services because Petitioner provides “non medical care, supervision when necessary to protect the health, safety, and well being of the enrollee, or social enrichment of a functionally impaired enrollee” to his wife, even though he is not compensated

for such services as a Direct Service Worker. Petitioner confirmed that he is able to provide and does provide Personal Care services and Homemaker services as his wife's Direct Service Worker. See supra ¶ 14. Petitioner also confirmed that he is able to provide and does provide Adult Companion Care services to his wife, even though he is not compensated to do so. See supra ¶ 14. At the hearing, Petitioner argued that a Medicaid recipient, such as himself, can be a paid caregiver for another Medicaid recipient providing the same LTC services to one another. However, based on the criteria set forth in the LTC Policy (General Criteria, Specific Criteria, and Medical Necessity), this argument is not supported.

29. In consideration of all the evidence in this case, the record does not indicate that Petitioner continues to require the LTC services at issue. Section 1.3.16 of the LTC Policy defines "natural support" as "[u]npaid supports that are provided voluntarily to the individual in lieu of home and community based services and supports." See supra ¶ 24. The record reflects the Petitioner lives with his wife and his wife is able to provide natural support of Personal Care services, Homemaker services, and Adult Companion Care services. See supra ¶ 23. Petitioner's wife does not work outside of the home and does not attend school outside of the home. See supra ¶ 3. Also, Petitioner's wife is very confident in her ability to continue providing care for Petitioner and is willing to provide same care to Petitioner. See supra ¶ 3. Petitioner's wife is not in crisis. See supra ¶ 3. Petitioner argues that Personal Care services, Homemaker services, and Adult Companion Care services should be reinstated because he relies upon the financial compensation from the PDO program to meet his living expenses. However, the LTC Policy and the Definitions Policy does not contemplate financial consideration in a Medical Necessity determination. Furthermore, to be medically necessary, the services at issue must "be furnished

in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.” The admitted evidence and testimony indicates that Petitioner’s ability to perform the services at issue for himself, and the natural support of his wife for these services, are sufficient to meet Petitioner’s needs. Thus, Petitioner no longer meets the following Medical Necessity standard: Services must 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.

30. Based on the record, Respondent has demonstrated that the Personal Care services, Homemaker services, and Adult Companion Care services at issue are in excess of the Petitioner’s needs at this time. Thus, the Petitioner does not meet this medical necessity standard, according to section 1.3.14 of the Definitions Policy and section 2.83 of the Definitions.

31. Accordingly, upon consideration of both parties’ admitted evidence, both parties’ sworn testimony, the LTC Policy, the PCS Policy, and the Definitions Policy, the undersigned Hearing Officer concludes that Respondent has shown by a preponderance of the evidence that Respondent’s termination of Personal Care services, Homemaker services, and Adult Companion Care services was correct.

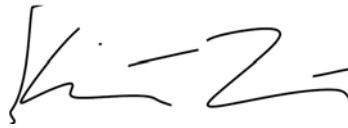
DECISION

Respondent’s termination of fourteen (14) hours per week of Personal Care services is **AFFIRMED**. Petitioner’s request for relief is hereby is **DENIED**.

Respondent’s termination of six (6) hours per week of Homemaker services is **AFFIRMED**. Petitioner’s request for relief is hereby is **DENIED**.

Respondent's termination of ten (10) hours per week of Adult Companion Care services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

DONE and ORDERED this 7th day of January, 2021, in Tallahassee, Leon County, Florida.



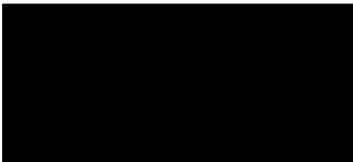
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Reason: 20-FH [REDACTED]; 20-FH [REDACTED];
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Date: 2021.01.07 13:05:35 -05'00'

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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

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