



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

FILED
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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 17, 2020, at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Authorized Representative

For the Respondent: Paige Comparato
Counsel for Respondent
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's adult companion care services from seventeen (17) to ten (10) hours weekly was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (" [REDACTED]"), Petitioner's Authorized Representative and daughter, represented Petitioner at the hearing.

Paige Comparato appeared as Counsel for Respondent. Dr. John Carter (“Dr. Carter”), Long Term Care Medical Director for Sunshine State Health Plan, Inc. (“Sunshine”), appeared as a witness for Respondent. Tracie Travis (Ms. Travis”), Case Management Supervisor, appeared as a witness for Respondent. The following individuals appeared as witnesses for Sunshine, but did not testify: Alsheneeka Williams, Care Coordinator Supervisor for Sunshine; Melissa Lane, Senior Manager for Member Appeals for Sunshine; and Ashley Bottin, Long Term Care Coordinator for Sunshine.

Marielisa Amador, Medical Health Care Program Analyst, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Petitioner did not present any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixteen (116)-page evidence packet. The evidence packet contains the following documents: Medicaid Fair Hearing Table of Content; Medicaid Fair Hearing Summary, dated November 18, 2020; Notice of Adverse Benefit Determination (“NABD”), dated August 17, 2020; Long Term Care Person-Centered Care Plan (“Care Plan”), signed August 5, 2020; Long Term Care Person-Centered Care Plan, unsigned and dated November 6, 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B Assessment”), dated August 5, 2020; 701B Assessment, dated November 2, 2020; letter from Petitioner, dated September 1, 2020; letter from [REDACTED] [REDACTED]), dated September 2, 2020; Request for Grievance of Appeal Form; Standard Appeal Acknowledgement, dated September 30, 2020; Notice of Plan Appeal Resolution (“NPAR”), dated October 23, 2020; Sunshine Health Policy and Procedure LT.UM.09;

and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010(166). Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine. *See* Respondent’s Composite Exhibit 1 at page 24. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is 59-years old. *Id.* at 15. Petitioner is legally blind and the following diagnoses: diabetes, high blood pressure, frequent headaches and dizziness, acid reflux, occasional incontinence of bladder, and depression. *Id.* at 37, 39 – 41. Petitioner’s primary language is [REDACTED] although he also understands and speaks English. *Id.* at 34.

3. Regarding Activities of Daily Living (“ADLs”), Petitioner needs assistance (but not total help) with bathing, dressing, using the bathroom. *Id.* at 37 and 55. Petitioner needs no assistance with eating. *Id.* Petitioner uses an assistive device with transferring and walking/mobility. *Id.* Petitioner needs assistance with bathing for safety reasons due to poor balance. *Id.* He is able to eat independently with meal preparation and set up. *Id.*

4. Regarding Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, preparing meals, and using transportation. *Id.* at 38 and 56. Petitioner needs assistance (but not total help) with using the telephone, managing money, and managing medication. *Id.* Petitioner has assistance with his IADLs most of the time. *Id.* Petitioner’s needs total assistance with preparing meals due to being legally blind and dizzy causing him to be a fall risk. *Id.*

5. Since 2011, Petitioner rents a room in the home of his [REDACTED] speaking caregiver. *Id.* at 34. Petitioner's caregiver works part-time outside the home. *Id.* at 65. Petitioner has no family living in the area. *Id.* at 27. The caregiver does the shopping and cooking for Petitioner. *Id.* at 38 and 56. The caregiver prepares breakfast, dinner, and snacks for Petitioner daily. *Id.* at 44. The 701B Assessments indicate that Petitioner is awake, alert and oriented, and he does not have a mental health condition requiring supervision. *Id.* at 35, 42, 53, and 60. Petitioner's caregiver provides a minimum of 40 hours per week of care and is very confident she will be able to continue caring for Petitioner. *Id.* at 48 and 66.

6. On August 17, 2020, Respondent issued an NABD reducing Petitioner's adult companion care services. *Id.* at 5. The NABD stated the reason for Respondent's actions as follows:

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: (See Rule)

...

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 not in excess of the patient's needs;
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 convenience of the recipient, the recipient's caretaker, 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: Sunshine Health has looked at the

member's present care needs and provided home services. The member's present care plan includes:

- 8 hours per week of Personal Care Services
- 15 hours per week of Homemaker Services
- 17 hours per week of Companion Care Services
- 7 meals per week of Home Delivered Meals

Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will reduce Companion Care Services from 17 hours per week to 10 hours per week, which is a reduction of 7 hours per week of Companion Care Services. The updated care plan approved by Sunshine Health will include:

- 8 hours per week of Personal Care Services
- 15 hours per week of Homemaker Services
- 10 hours per week of Companion Care Services
- 7 meals per week of Home Delivered Meals

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Services Criteria.

Id. at 4 - 6.

7. In a letter dated September 2, 2020, Petitioner's physician, [REDACTED], stated, "Petitioner is legally blind. He requires 40 hours of home care per week." *Id.* at 70.

8. Petitioner requested a plan appeal on September 23, 2020, and received an NPAR dated October 23, 2020, upholding Sunshine's decision to reduce Petitioner's companion care services.

Id. at 78 - 80. The NPAR explained as follows:

On September 23, 2020 we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated August 17, 2020, Notice of Adverse Benefit Determination Number [REDACTED], reducing the Companion Care Services from 17 hours per week to 10 hours per week, which is a reduction of 7 hours per week of Companion Care Services (the person who helps and watched over you, provided to [Petitioner]).

On October 23, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby denies your plan appeal. As a result, [Petitioner] will not receive the 7 hours per week of Companion Care Services (the person who helps and watches over you), effective October 23, 2020.

The reason for our decision was:

...

Based on the assessment of your care needs and household and caregiver status, Sunshine Health reduced the Companion Care Services (the person who helps and watches over you) from 17 hours per week to 10 hours per week, which is a reduction of 7 hours per week of Companion Care Services.

The updated care plan approved by Sunshine Health remains:

- 8 hours per week of Personal Care Services
- 15 hours per week of Homemaker Services
- 10 hours per week of Companion Care Services
- 7 meals per week of Home Delivered Meals

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 78 - 79.

9. Respondent relied upon the LTC Ancillary Service Criteria to make its Medical Necessity determination. See Respondent's Composite Exhibit 1, pages 85-115. The LTC Ancillary Service Criteria states as follows regarding Adult Companion Care services:

1. Determinants for Services

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)

- Independent where member is able to provide the task without support, with or without assistive devices
- Minimal functional impairment where the ADL's require one of the following:
 - Supervision
 - At least minimum assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance
- Moderate functional impairment where two of the follow apply
 - Member has ADLs requiring at least minimal assistance
 - Member ambulates with assistance of a person or device
 - Member transfers require at least minimum assistance
- Maximum and persistent functional impairment without available caregiver support where all of the following exist:

- Member has ADLs requiring total assistance
- Member is non-ambulatory
- Member transfers require one (1) to two (2) person assist
- Member's treating physician has certified that member meets Maximum functional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member). Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

2. Adult Companion Care

Adult Companion Care services provide non-medical care, supervision, and socialization to a functionally impaired adult. Companions supervise the member with tasks such as meal preparation, laundry, and/or shopping, but do not perform these activities as discreet services. The provision of companion services does not

entail hands-on nursing care. The service includes light housekeeping tasks incidental to the care and supervision of the member. The provision of services is provided at the member's residence when supervision is necessary.

Approval Criteria

To be considered for Adult Companion Care Services, a member must have a qualifying trigger diagnosis and meet the minimal criteria for the four (4) dimensions of determination as discussed here.

a) Trigger diagnosis include:

- Advanced Alzheimer's disease & dementia
- Mental Illness requiring supervision
- Parkinson's disease
- Multiple Sclerosis
- ALS
- Congestive Heart Failure
- COPD
- Cancer
- End Stage Renal disease
- TBI
- Other diagnosis as deemed medically necessary by Medical Director

b) Four (4) Dimensions of Determination

- Need for Supervision – safety risk if left without supervision
 - See Section C.1.c. for more details
- Informal Supports
 - None
 - Few friends/family in area
 - Family nearby
- Living Situation
 - Lives alone
 - Lives with others but is alone for extended periods of time due to the necessary absence of a caregiver
 - Lives with caregiver and others
- Services in Place
 - Sunshine Health provided and provided by other provider/insurance

Exclusions and Limitations for Adult Companion Care include but are not limited to:

1. Service must be provided at member's residence.
2. Member must reside in a non-facility based setting.
3. Member resides alone or resides with others and is left alone for long periods where member is at risk.
4. Member is at risk of social isolation.

5. Member has cognitive impairment that prevents them from knowing when or how to carry out personal care tasks.
6. The member has memory deficits, which prevent him or her from managing care tasks.
7. Member requires hands on assistance to carry out ADL tasks.
8. Member attends Adult day care or engages in community group or social events, unless service is needed for supervision. The provider must be awake during the provision of companion services, and the services shall not be provided overnight.
9. Adult Companion Care services provided by Sunshine Health may not duplicate services that are provided under by another provider.
10. Cognitive ability of member to engage in and comprehend conversation with others
11. Care, grooming, or feeding of pets and animals
12. Yard work, gardening, or home

Respondent's Composite Exhibit 1, pages 89 – 92.

10. Petitioner is currently approved to receive 8 hours of personal care services weekly, 10 hours of companion care services weekly, 15 hours of homemaker services weekly, and 7 meals per week of Home Delivered Meals. *Id.* at 3.

11. Dr. Carter is a Long Term Care Medical Director for Sunshine. He is board certified in internal medicine, geriatric medicine, hospice medicine, and palliative care. Dr. Carter testified that Petitioner's 701B Assessments describe Petitioner's medical conditions, functional difficulties, and living arrangements. Dr. Carter argued that the Medical Director who initially reviewed Petitioner's case concluded that the previously approved hours are excessive based on Petitioner's medical needs and home environment. Dr. Carter contended that he also reviewed Petitioner's case and agrees with the reduction of companion care hours.

12. Dr. Carter explained that companion care services are not intended to be "hands on" services; rather, they are intended to provide supervision or companionship. Dr. Carter asserted that, based on Petitioner's 701B Assessments, Petitioner is visually impaired, uses a walker for

mobility, and requires partial assistance with his ADLs. Dr. Carter argued that 17 hours per week of companion care services is in excess of Petitioner's need in light of the fact that: Petitioner lives with another occupant who only works part-time; Petitioner is awake, alert and oriented; Petitioner transfers with assistive devices; and Petitioner is able to use the phone. Dr. Carter argued that the approved total of 33 hours per week of combined services is adequate to meet Petitioner's need.

13. Ms. Travis asserted that, at this time, Petitioner resides with his caregiver and is not at risk for social isolation. Ms. Travis agreed with Dr. Carter that the approved level of combined services is adequate to meet Petitioner's need. Ms. Travis further asserted that Petitioner can submit a modification request if his circumstances change in the future.

14. ██████████ testified that Petitioner's eyesight is deteriorating. She asserted that Petitioner decided to stop using Home Delivered Meals in an effort to control his blood sugar and have a healthier diet. She argued that, because of this, it takes longer for Petitioner's caregiver to prepare his meals. ██████████ asserted that Petitioner is unable to prepare his own meals due to poor eyesight.

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 section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of the Agency under section 409.285(2)(a).

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

17. Because Respondent is reducing previously approved services, Fla. Admin Code R. 59-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence.” (Black’s Law Dictionary at 1201, 7th Ed.)

18. The Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to personal care, adult companion care, and homemaker services:

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.

...

1.3.1 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

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation

- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.16 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 LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service
- Meet the criteria as specified in this policy

...

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.

...

4.2.1.9 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.

...

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

LTC Policy at pages 1 - 8.

19. The LTC Policy also addresses medical necessity:

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.

LTC Policy at pages 2 – 3.

20. The Florida Medicaid Authorization Requirements Policy, June 2016, (“Authorizations Policy”) states in pertinent part, as follows:

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

1.1.1 Florida Medicaid Policies

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients through the fee-for-service delivery system, unless otherwise specified. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

...

1.2 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 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for service providers (also known as the QIO).

2.4.3 Modifications

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized. Providers must

submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

Authorizations Policy, pages 1 and 3.

21. The Florida Medicaid Definitions Policy (August 2019) ("Definitions Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

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 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.

22. Respondent reduced Petitioner's companion care services from seventeen (17) hours weekly to ten (10) hours weekly. See supra ¶ 6 and 8. Respondent's rationale for reducing the services was that Petitioner's request failed to meet the requirements of medical necessity; specifically, Respondent stated that the companion care services at issue are in excess of Petitioner's needs. See supra ¶ 6, 8, and 11 - 13.

23. As provided in the LTC Policy, the purpose of adult companion care services is to provide "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.” See supra ¶ 18. Companion care is designed to prevent social isolation or to provide supervision to protect the enrollee’s safety. See supra ¶ 18.

24. Petitioner is a 59-year-old male residing with his caregiver, who works outside the home on a part-time basis. See supra ¶ 2 and 5. Petitioner has no family members living nearby. See supra ¶ 5. Petitioner is legally blind, and his medical conditions include diabetes, high blood pressure, frequent headaches and dizziness, acid reflux, occasional incontinence of bladder, and depression. See supra ¶ 2 and 7. Petitioner is awake, alert and oriented, and he does not have a mental health condition requiring supervision. See supra ¶ 5.

25. Petitioner needs assistance (but not total help) with ADLs, such as bathing, for safety reasons due to poor balance. See supra ¶ 3. Petitioner is able to eat independently but needs total assistance with meal preparation and set-up from his caregiver. See supra ¶ 3, 4 and 14. Petitioner also needs total assistance (cannot do at all) with heavy chores, light housekeeping, and using transportation. See supra ¶ 4. Petitioner is a fall risk due to being legally blind and experiencing dizziness. See supra ¶ 4. ██████████ contends that Petitioner needs 17 hours per week of companion care services because it takes his caregiver more time to prepare meals now that Petitioner terminated Home Delivered Meals. See supra ¶ 14.

26. Based on the record, Respondent reduced Petitioner’s Companion Care services for not meeting section 1.3.14 of the LTC Policy which requires that “LTC supportive services must . . . [b]e individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.” See supra ¶ 6, 8, 11-13 and 19.

27. The record indicates that 17 hours per week of Adult Companion Care services are in excess of the Petitioner's needs. The record indicates that Petitioner is legally blind and experiences dizziness among other medical conditions. See supra ¶ 2. However, Petitioner lives with his caregiver who works part time. See supra ¶ 5. Petitioner uses a walker for mobility, and requires partial assistance with his ADLs. See supra ¶ 3. Petitioner is awake, alert and oriented, transfers with assistive devices, and able to use the phone. See supra ¶ 3, 4, and 12. As Dr. Carter testified, companion care services are not intended to be "hands on" services; rather, they are intended to provide supervision or companionship. See supra ¶ 12. Dr. Carter asserted that the approved 10 hours of companion care weekly give Petitioner a total of 33 hours per week of combined services, which is sufficient to meet his needs. See supra ¶ 12.

28. ██████████ argued that Petitioner needs 17 hours per week of companion care services for meal preparation. See supra ¶ 14. She asserted that Petitioner's caregiver spends more time preparing meals since Petitioner discontinued Home Delivered Meals. See supra ¶ 14. The record demonstrates that Petitioner's caregiver provides a minimum of 40 hours per week of care, and she is very confident she will be able to continue caring for Petitioner. See supra ¶ 5. Section 1.3.16 of the LTC Policy provides that natural supports are "[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports." See supra ¶ 18. There is no evidence in the record suggesting that Petitioner's caregiver is no longer willing to provide natural supports for Petitioner. Further, as ██████████ testified, if Petitioner's circumstances change in the future, he may request a modification of the care plan. See supra ¶ 13. In light of Petitioner's current needs, currently approved services, and natural support,

Respondent demonstrated that that 17 hours per week of adult companion care services are in excess of Petitioner's needs.

29. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent met its burden of proving that 17 hours per week of adult companion care services are not medically necessary for Petitioner.

30. Accordingly, the undersigned Hearing Officer concludes that Respondent proved by a preponderance of the evidence that Respondent's reduction of companion care services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent's reduction of adult companion care services is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction is **DENIED**.

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



Laura Gallagher
20-FH-
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LAURA GALLAGHER, Hearing Officer
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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.

Copies Furnished To:



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