



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

FILED

Apr 07, 2021, 9:01 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 9, 2021, at [REDACTED]

APPEARANCES

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

For the Respondent: Roberta Frank
Nurse Appeals Associate
Simply Healthcare Plans, Inc.

STATEMENT OF ISSUE

The first issue (AHCA Case Number 21-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional four (4) hours per week of homemaker services was incorrect.

The second issue (AHCA Case Number 21-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional seven (7) hours per week of adult companion care services was incorrect.

The third issue (AHCA Case Number 21-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of six (6) hours per week of personal care services was incorrect.

The fourth issue (AHCA Case Number 21-FH [REDACTED]) is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's respite care services (13 hours per week) was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] Petitioner's Authorized Representative and son, appeared at the Fair Hearing and provided testimony on Petitioner's behalf.

Roberta Frank ("Ms. Frank"), Nurse Appeals Associate for Simply Health Care Plans, Inc. ("Simply" or "Respondent"), represented Respondent at the hearing. Dr. Marc Kaprow ("Dr. Kaprow"), Long Term Care Medical Director for Simply, appeared as a witness for Respondent. Susie Poli, Utilization Manager for Simply, appeared as a witness but did not testify.

There was no representative from the Agency for Health Care Administration ("Agency" or "AHCA") at the Fair Hearing.

Interpreter Stephanie, translator number 335136 with CyraCom, appeared for the hearing and provided translation services on behalf of Petitioner.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and twenty-six (226)-page evidence packet. The evidence packet consisted of the following documents: letter from Angela Royster, dated February 8, 2021 in Spanish and English; Table of Contents in Spanish and English; Sequence of Events in Spanish and English; Anthem Monthly Contact log; Anthem Natural Disaster Plan; Anthem Member Centric Goals; Comprehensive Plan of Care, review date November 5, 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B Assessment"), dated [REDACTED] 2020; fax cover

page, dated November 5, 2020; Simply Healthcare SMMC-LTC Service Request Form, dated November 5, 2020; 701B Assessment, dated [REDACTED] 2020; Comprehensive Plan of Care, review date November 5, 2020; Prior Authorization Notes; Notice of Adverse Benefit Determination (“NABD”) letter for personal care services, companion care services, and homemaker services, dated November 11, 2020, in Spanish and English; NABD for respite care services, dated November 11, 2020, in Spanish and English; Member Appeal Notes; Notice of Plan Appeal Resolution (“NPAR”) for personal care services, companion care services, homemaker services, and respite care services, dated December 11, 2020, in Spanish and English; Anthem Monthly Contact log; Anthem Face to Face Visit log; Anthem Natural Disaster Plan; Anthem Member Centric Goals; Comprehensive Plan of Care, review date January 13, 2021; Plan of Care Summary, review date January 13, 2021 (“most recent Plan of Care”); 701B Assessment (“most recent 701B Assessment”), dated [REDACTED] 2021; letter to Petitioner, dated January 22, 2021, in Spanish and English; and Florida Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”). Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Prior to hearing, Respondent also sent to the Office of Fair Hearings and Petitioner an updated Notice of Plan Appeal Resolution (“updated NPAR”), dated February 9, 2021, in Spanish and English. Absent an objection from Petitioner, the undersigned admitted the updated NPAR into evidence as Respondent’s Exhibit 2.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply. See Respondent's Composite Exhibit 1 at page 11. Simply is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. *Id.* at 38-39.

2. Petitioner is 72-years old who suffers from acid reflux/GERD, rheumatoid arthritis, high blood pressure, diabetes, frequent dizziness, frequent bladder incontinence, Chronic Obstructive Pulmonary Disease ("COPD"), osteoporosis, asthma, diverticulitis, reconstruction of the cornea, knee replacement, and depression. *Id.* at 165, 171 and 173. Petitioner's son moved to [REDACTED] and Petitioner currently lives alone in a private residence. *Id.* at 39 and 166. Petitioner uses oxygen several times a day for COPD. *Id.* at 172. According to the testimony of [REDACTED] Petitioner experiences frequent pain.

3. Regarding Activities of Daily Living ("ADLs"), Petitioner: needs assistance (but not total help) with bathing and dressing; Petitioner uses an assistive device with using the bathroom, transferring, and walking/mobility; and Petitioner needs no assistance with eating. *Id.* at 169. Petitioner always has assistance with bathing, dressing, using the bathroom, transferring, and walking/mobility. *Id.*

4. Regarding Instrumental Activities of Daily Living ("IADLs"), Petitioner: needs total assistance (cannot do at all) with heavy chores and light housekeeping; Petitioner needs assistance (but not total help) with preparing meals, shopping and using transportation; and Petitioner needs no assistance using the telephone and managing money. *Id.* at 170. Petitioner always has assistance with heavy chores, light housekeeping, preparing meals, shopping, managing medication, and using transportation. *Id.*

5. Petitioner talks to friends, relatives or others (by phone, computer, or other means) two to six times a week. *Id.* at 179. Petitioner spends time with someone who does not live with her two to six times per week. *Id.* Petitioner participates in activities outside the home every few months. *Id.*

6. In Petitioner's most recent 701B Assessment, the box "[n]ot at all" was checked for the following behaviors: forgetful or easily confused; gets lost or wanders off; intentionally injures or harms herself; expresses suicidal feelings or plans; or hallucinates, hears/sees things that are not there. *Id.* at 174. Petitioner does not need supervision. *Id.* This information is consistent with Petitioner's previous 701B Assessment, dated [REDACTED] 2020. *Id.* at 49.

7. Petitioner requested an additional six (6) hours per week of personal care, an additional four (4) hours per week of homemaker service, twenty (20) hours per week of companion care services, and the continuation of 13 hours per week of respite care service. *Id.* at 66 – 67.

8. On November 11, 2020, Respondent issued an NABD partially denying Petitioner's request for additional personal care services, homemaker services, and companion care services. *Id.* at 84 – 87. The NABD stated the reason for the partial denial 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: We can cover some of the hours of the companion care (APPROVE: S5135- COMPANION CARE-13 HOURS PER WEEK). We cannot cover the extra hours of the homemaker care (DENY: S5130-HOMEMAKER CARE ADDITIONAL 4 HOURS PER WEEK). We cannot cover the extra hours of the personal care (Deny : T1019- PERSONAL CARE- ADDITIONAL 6 HOURS PER WEEK). We cannot cover some of the hours of the companion care (DENY: S5135- COMPANION CARE-7 HOURS PER WEEK). We will stop the respite care (TERMINATE: S5150 - RESPITE CARE - 13 HOURS PER WEEK). You have problems with your health. You need some help to bathe. You need some help to get dressed. You are not bed bound. You walk with a walker. You will be living alone. You have personal care hours now. You have homemaker care hours now. You have respite care hours now. The companion care hours will help you. This help should be able to be arranged for your needs. The respite care is not needed. You do not live with a caregiver. All of the extra hours that you asked are not medically needed at this time. This decision was based on your records 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.

Id. at 84 - 85.

9. On November 11, 2020, Respondent issued an NABD terminating Petitioner's respite care services. *Id.* at 105 – 108. The NABD stated the reason for the reduction 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: We can cover some of the hours of the companion care (APPROVE: S5135- COMPANION CARE-13 HOURS PER WEEK). We cannot cover the extra hours of the homemaker care (DENY: S5130-HOMEMAKER CARE ADDITIONAL 4 HOURS PER WEEK). We cannot cover the extra hours of the personal care (Deny : T1019- PERSONAL CARE- ADDITIONAL 6 HOURS PER WEEK). We cannot cover some of the hours of the companion care (DENY: S5135- COMPANION CARE-7 HOURS PER WEEK). We will stop the respite care (TERMINATE: S5150 - RESPITE CARE - 13 HOURS PER WEEK). You have problems with your health. You need some help to bathe. You need some help to get dressed. You are not bed bound. You walk with a walker. You will be living alone. You have personal care hours now. You have homemaker care hours now. You have respite care hours now. The companion care hours will help you. This help should be able to be arranged for your needs. The respite care is not needed. You do not live with a caregiver. All of the extra hours that you asked are not medically needed at this time. This decision was based on your records 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.

Id. at 105 – 106.

10. Petitioner requested a plan appeal and received an NPAR, dated December 11, 2020, upholding Simply's decision to partially deny Petitioner's request for additional personal care,

homemaker, and adult companion care services, and Simply's decision to terminate respite care services. *Id.* at 122 - 125. The NPAR explained as follows:

On 11/13/2020 we received your timely plan appeal request regarding Simply Healthcare Plans, Inc.'s Notice of Adverse benefit Determination dated 11/11/2020, NABD Number [REDACTED] APARTIALLY DENYING, the T1019-PC-ADDT 6 HOURS PER WK; -S5130 – HMK – ADDT 4 HOURS PER WK; - S5135-COMP-7 HOURS PER WK provided to [Petitioner]. We can cover some of the hours of companion care (APPROVE: S5135 – COMPANION CARE – 13 HOURS PER WEEK). We cannot cover the extra hours of the homemaker care (DENY: S5130-HOMEMAKER CARE-ADDITIONAL 4 HOURS PER WEEK). We cannot cover the extra hours of the personal care (Deny: T1019-PERSONAL CARE-ADDITIONAL 6 HOURS PER WEEK). We cannot cover some of the hours of the companion care (DENY" S5135 – COMPANION CARE – 7 HOURS PER WEEK. We will stop the respite care (TERMINATE: S5150 – RESPITE CARE – 13 HOURS PER WEEK). You have problems with your health. You need some help to bathe. You need some help to get dressed. You are not bed bound. You walk with a walker. You will be living alone. You have personal care hours now. You have homemaker care hours now. You have respite care hours now. The companion care hours will help you. This help should be able to be arranged for your needs. The respite care is not needed. You do not live with a caregiver. All of the extra hours that you asked are not medically needed at this time. This decision was based on your records and the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy.

On 12/08/2020, after consideration of the information you provided to Simply in support of your plan appeal, Simply hereby DENIES your plan appeal. Based on your records and the Florida Medicaid Statewide Managed Care Long Term Care Program Coverage Policy, 6.2 the denial for more care hours (personal-care, additional 6 hours weekly; homemaker care, additional 4 hours weekly; companion care, additional 7 hours weekly) is UPHELD. We know you have health problems (arthritis, diabetes, incontinence, depression). You are able to use a walker. You are able to help with your own care. You have family they can help you. We know you live alone. The amount of care you are getting is enough to meet your needs. The extra hours you asked for are not needed. This is why they are not approved. Your case was looked at by a Internal Medicine, Hospice & Palliative Medicine Provider for Simply.

Id. at 122 - 123.

11. On February 9, 2021, Respondent issued an amended NPAR approving Petitioner's request for additional personal care services and homemaker services. See Respondent's Exhibit

2. The amended NPAR states:

On 01/22/2021 we received your timely request for a Medicaid Fair Hearing regarding Simply Healthcare Plans, Inc.'s Notice of Adverse Benefit Determination dated 11/10/2020, NABD Number [REDACTED] PARTIALLY DENYING/TERMINATING home health services, provided to [Petitioner]. We can cover some of the hours of the companion care (APPROVE: S5135- COMPANION CARE-13 HOURS PER WEEK). We cannot cover the extra hours of the homemaker care (DENY: S5130-HOMEMAKER CARE-ADDITIONAL 4 HOURS PER WEEK). We cannot cover the extra hours of the personal care (Deny : T1019- PERSONAL CARE-ADDITIONAL 6 HOURS PER WEEK). We cannot cover some of the hours of the companion care (DENY: S5135- COMPANION CARE-7 HOURS PER WEEK). We will stop the respite care (TERMINATE: S5150 Ć RESPITE CARE - 13 HOURS PER WEEK). You have problems with your health. You need some help to bathe. You need some help to get dressed. You are not bed bound. You walk with a walker. You will be living alone. You have personal care hours now. You have homemaker care hours now. You have respite care hours now. The companion care hours will help you. This help should be able to be arranged for your needs. The respite care is not needed. You do not live with a caregiver. All of the extra hours that you asked are not medically needed at this time. This decision was based on your records and the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy.

On 2/9/2021 after consideration of the information you provided to Simply in support of your Medicaid Fair Hearing appeal, Simply hereby PARTIALLY APPROVES your plan appeal. Based on your record and the Florida Medicaid Statewide Managed Care Long Term Care Program Coverage Policy, 6.2 the denial of services is PARTIALLY OVERTURNED. We will cover the extra six (6) hours of weekly personal care you asked for. We will cover the extra four (4) hours of weekly homemaker care you asked for. Your case manager had a visit a few weeks ago. Your condition has changed since we denied these hours. You are more short of breath. You are weaker. This care is needed for your hands on care. This care is needed to help you in your home. We will still not cover the extra companion care you asked for (extra 7 hours weekly). We will not restart the respite care that was stopped (respite care, 13 hours weekly). You no longer live with a caregiver. Respite care is to give your caregiver a break. Because you don't have a caregiver in your home, this is no longer needed. The respite care was changed to companion care. Companion care is to keep you company. Companion care can help with non-hands on tasks. You are getting enough care to help with this. The

extra hours you are asking for is still not needed. You can use the approved hours as you wish, to meet your needs. Your case was looked at by a Internal Medicine, Hospice & Palliative Medicine Doctor for Simply.

Id. at 2 – 3.

12. On January 15, 2021, Petitioner's Authorized Representative timely requested a Fair Hearing. After a continuance was granted, the undersigned scheduled the Fair Hearing for March 9, 2021, at [REDACTED] and all parties were duly notified.

13. As [REDACTED] testified, Petitioner suffers from rheumatoid arthritis and COPD. Further, Petitioner experiences extreme pain, which has resulted in stronger pain medications. Petitioner spends many hours alone at home.

14. According to Dr. Kaprow's testimony, Simply received a request for additional services in November 2020, based on information indicating that Petitioner's caregiver would no longer be living with her. At that time, Simply converted Petitioner's 13 hours per week of respite care services to 13 hours per week of companion care services. Respite care is used when there is a caregiver present as a natural support. It provides the member with services when the natural support is unavailable for short periods of time. In December 2020, Dr. Kaprow reviewed Petitioner's appeal and upheld the decisions made. In February 2020, Simply received additional information concerning a change in Petitioner's medical condition. At that time, Petitioner's case manager noted that Petitioner needs additional oxygen and was having more difficulty walking. Based on that information, Simply overturned the denial of additional personal care services and homemaker services. In evaluating the case at that time, Dr. Kaprow found no further change in Petitioner's living conditions. He argued that the additional services are sufficient to cover

Petitioner’s medical needs, and additional companion care and a reversal of respite care services are not appropriate.

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 Petitioner is requesting new services with regard to Issue numbers one through three (1 – 3), *supra* page 2, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. Because Respondent is terminating respite care services in Issue number four (4), *supra* page 3, Fla. Admin Code R. 59G-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 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, homemaker, and respite care 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)

...

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.

...

4.2.1.15 Respite Care

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis.

...

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 Definitions Policy (August 2017) (“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.

Homemaker Services

21. In the NPAR dated December 11, 2020, Respondent denied Petitioner’s request for four (4) additional hours per week of homemaker services. *See supra* ¶ 10. On February 9, 2021, the Respondent issued an amended NPAR, which authorized the four (4) additional hours per week of homemaker services that Petitioner requested. *See supra* ¶ 11.

22. Pursuant to Rule 59G-1.100(9)(b)(6), Florida Administrative Code, the Hearing Officer is authorized to dismiss a request for a Fair Hearing because it is moot. The Florida Supreme Court explained in *Godwin v. State*, 593 So.2d 211 (1992) (citing *Dehoff v. Imeson*, 153 Fla. 553 (1943)) that “[a]n issue is moot when the controversy has been so fully resolved that a judicial determination can have no actual effect. . . . A case is ‘moot’ when it presents no actual controversy or when the issues have ceased to exist.” See also *J.W. v. Agency for Health Care Admin.*, 178 So. 3d 542, 544–45 (Fla. 1st DCA 2015) (explaining that because J.W. received the requested treatment, “DCF was correct to dismiss J.W.’s fair hearing request under these circumstances because, once he received the continued psychiatric treatment he’d asked for, he no longer needed agency review of Magellan’s decision not to authorize the treatment. Rather, the issue at that point became whether Flagler Hospital could be paid by Medicaid for the services it had rendered *without prior authorization.*”) (emphasis in original).

23. At the Fair Hearing, the parties stipulated on the record that the four (4) additional hours per week of homemaker services requested by Petitioner were approved in the amended NPAR and that this issue is resolved.

24. In light of the fact that Respondent authorized the requested homemaker services at issue for an additional four (4) hours per week of homemaker services, the undersigned Hearing Officer concludes that there is no relief that can be granted at a Fair Hearing on the issue of homemaker services in AHCA Case Number 21-FH [REDACTED] at this time.

Adult Companion Care Services

25. In this case, Petitioner is currently approved for 13 hours per week of adult companion care services, and she requested an additional 7 hours per week at issue in this case.

26. 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. See *supra* ¶ 11.

27. Petitioner resides alone in a private residence. See *supra* ¶ 2. The record reflects that Petitioner needs some assistance (but not total help) with her ADLs and that Petitioner always has assistance with bathing, dressing, using the bathroom transferring and walking/mobility. See *supra* ¶ 3. Further, Petitioner needs total assistance (cannot do at all) with heavy chores and light housekeeping; Petitioner needs assistance (but not total help) with preparing meals, shopping and using transportation; Petitioner needs no assistance using the telephone and managing money. See *supra* ¶ 4. Petitioner always has assistance with heavy chores, light housekeeping, preparing meals, shopping, managing medication, and using transportation. See *supra* ¶ 4.

28. The record reflects that Petitioner is not at risk of social isolation. See *supra* ¶ 13. According to the most recent 701B Assessment, Petitioner needs no assistance using the telephone. See *supra* ¶ 4. She talks to friends, relatives or others (by phone, computer, or other means) two to six times a week. See *supra* ¶ 5. Petitioner spends time with someone who does not live with her two to six times per week. See *supra* ¶ 5. Petitioner participates in activities outside the home every few months. See *supra* ¶ 5. Further, Petitioner is approved for 13 hours per week of companion care as well as 10 hours per week of additional paid services, which provide opportunities for socialization. See *supra* ¶ 11. ██████████ testified that Petitioner spends many hours alone, *supra* ¶ 13; however, Petitioner offered no testimony or other evidence supporting Petitioner’s request for 7 additional hours of companion care service.

29. With regard to a medical need for companion care supervision, ██████████ testified that Petitioner suffers from rheumatoid arthritis and COPD. She uses oxygen and experiences extreme pain. See supra ¶ 12. Dr. Kaprow testified that Simply took these conditions into account when approving additional personal care and homemaker services in the amended NPAR. See supra ¶ 11 and 14. Further, in Petitioner’s most recent 701B Assessment, the box “[n]ot at all” was checked for the following behaviors: forgetful or easily confused; gets lost or wanders off; intentionally injures or harms herself; expresses suicidal feelings or plans; or hallucinates, hears/sees things that are not there. See supra ¶ 6. Furthermore, the assessment expressly indicates that Petitioner does not need supervision. See supra ¶ 6.

30. Petitioner did not submit evidence as to how many additional hours of companion care are medically necessary. As such, Petitioner failed to demonstrate that the requested adult companion care service hours are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and are not in excess of the Petitioner’s needs.

31. Therefore, upon consideration of both parties’ testimony, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the LTC Policy, and the Definitions Policy, the undersigned finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of additional adult companion care services was incorrect.

Personal Care Services

32. In the NPAR dated December 11, 2020, Respondent denied Petitioner’s request for six (6) additional hours per week of personal care services. See supra ¶ 10. On February 9, 2021,

Respondent issued an amended NPAR authorizing the six (6) additional hours per week of personal care services that Petitioner requested. *See supra* ¶ 11.

33. Pursuant to Rule 59G-1.100(9)(b)(6), Florida Administrative Code, the Hearing Officer is authorized to dismiss a request for a Fair Hearing because it is moot. The Florida Supreme Court explained in *Godwin v. State*, 593 So.2d 211 (1992) (*citing Dehoff v. Imeson*, 153 Fla. 553 (1943)) that “[a]n issue is moot when the controversy has been so fully resolved that a judicial determination can have no actual effect. . . . A case is ‘moot’ when it presents no actual controversy or when the issues have ceased to exist.” *See also J.W. v. Agency for Health Care Admin.*, 178 So. 3d 542, 544–45 (Fla. 1st DCA 2015) (explaining that because J.W. received the requested treatment, “DCF was correct to dismiss J.W.’s fair hearing request under these circumstances because, once he received the continued psychiatric treatment he’d asked for, *he* no longer needed agency review of Magellan’s decision not to authorize the treatment. Rather, the issue at that point became whether Flagler Hospital could be paid by Medicaid for the services it had rendered *without prior authorization.*”) (emphasis in original).

34. At the Fair Hearing, the parties stipulated on the record that the additional six (6) hours per week of personal care services requested by Petitioner were approved in the amended NPAR and that this issue is resolved.

35. In light of the fact that Respondent authorized the requested personal care services at issue for an additional six (6) hours per week of personal care services, the undersigned Hearing Officer concludes that there is no relief that can be granted at a Fair Hearing on the issue of personal care services in AHCA Case Number 21-FH [REDACTED] at this time.

Respite Care Services

36. In the instant case, respondent terminated 13 hours per week of in-home respite care services. As established on the record by the evidence and testimony, Respondent terminated in-home respite care services because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary.

37. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the SMMC LTC Policy; do not duplicate another service; and meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 18.

38. Section 4.2.1.15 of the PTC Policy provides that respite care services are the "provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis." *See supra* ¶ 18.

39. The evidence presented in this case reflects that the termination of in-home respite care services was warranted under the circumstances of this case. *See supra* ¶ 9 - 11. Petitioner's son is no longer living with her. *See supra* ¶ 12 and 13. As Petitioner is not receiving care from a natural support and respite care services are to relieve a natural support, the record shows that respite care services are not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and [are]in excess of the patient's needs." *See supra* ¶ 19.

40. Therefore, upon consideration of both parties' testimony, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the LTC Policy, and the Definitions Policy, the undersigned concludes that Respondent proved by a preponderance of the evidence that Respondent's termination of respite care services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

AHCA Case Number 20-FH0171 is dismissed as **MOOT**, and is now closed.

Respondent's denial of seven (7) additional hours of adult companion care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

AHCA Case Number 20-FH0173 is dismissed as **MOOT**, and is now closed.

Respondent's termination of respite care services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

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



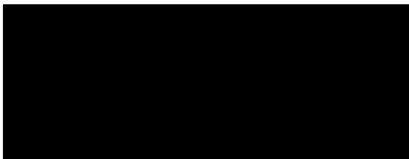
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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 CHEADQUARTERS 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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