



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

FILED

Sep 25, 2023, 10:46 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1715

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on September 5, 2023, at 1:11 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Yuneisy Cruz

Director of Healthcare Services for Long-Term Care

Molina Healthcare of Florida

STATEMENT OF ISSUE

The first issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of homemaker services from eight (8) hours per week to three (3) hours per week was correct.

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services from thirty (30) hours per week to twenty-seven (27) hours per week was correct.

The third issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of five (5) hours per week of adult companion care services was correct.

PRELIMINARY STATEMENT

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

Yuneisy Cruz, Director of Healthcare Services for Long-Term Care, represented the Respondent, Molina Healthcare of Florida ("Molina Healthcare"), at the Fair Hearing and provided testimony. Caatia Matos, Utilization Director, also provided testimony on behalf of Respondent at the Fair Hearing. The following employees of Molina Healthcare attended the Fair Hearing as witnesses but did not testify: Caridad Bello, Government Contract Specialist; Yani Veliz, Director of Appeals and Grievances; and Shakesha Gantt, Manager of Healthcare Services for Long-Term Care.

Suzanne Chillari, Medical Health Care Program Analyst for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent two (2) page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "Member Documents Received (1).pdf", "23-FH1715 Doctor's

Letter.pdf". Absent an objection from Respondent, the undersigned admitted Petitioner's evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and fourteen (114)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "MFH Office Packet_1.pdf," "MFH Office Packet_2.pdf," "MFH Office Packet_3.pdf," "MFH Office Packet_4.pdf," "MFH Office Packet_5.pdf," "MFH Office Packet_6.pdf," "MFH Office Packet_7.pdf," and "MFH Office Packet_8.pdf." Absent an objection from Petitioner, the undersigned admitted Respondent's evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of Molina Healthcare's LTC plan. See RCE 1, page 1. Molina Healthcare is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in the State of Florida.

2. As of the time of the hearing, Petitioner is [REDACTED] and lives with [REDACTED].
[REDACTED] *Id.* at 3, 13.

3. Petitioner has the following health conditions: [REDACTED].
[REDACTED] *Id.* at 9 – 10. Petitioner has not become concerned about [REDACTED] and does not have [REDACTED]. *Id.* at 5. Petitioner does not have the problem behaviors of [REDACTED].
[REDACTED] *Id.* at 10. Petitioner does not need supervision. *Id.*

4. [REDACTED] assisted Petitioner with answering the questions on Petitioner's Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated May 2, 2023 ("701B

Assessment”). *Id.* at 4. [REDACTED] answered question 77 stating Petitioner is about the same as [REDACTED] was this time last year. *See* RCE 1 at 11. [REDACTED] answered question 133 stating that [REDACTED] was very confident in [REDACTED] ability to continue to provide care for Petitioner. *See* RCE 1 at 18.

5. According to the 701B Assessment, regarding Petitioner’s Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED]. [REDACTED] needs assistance (but not total help) with [REDACTED] and uses an assistive device for [REDACTED]. *Id.* at 7. Petitioner always has assistance with [REDACTED]. *Id.* Petitioner has assistance most of the time with [REDACTED]. *Id.*

6. According to the 701B Assessment, regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED]. [REDACTED]. *Id.* at

8. Petitioner needs assistance (but not total help) with [REDACTED]. [REDACTED]. *Id.* Petitioner always has assistance with [REDACTED]. [REDACTED].

Id. Petitioner has assistance most of the time with [REDACTED]. *Id.*

7. The notes and summary of the 701B Assessment observe, in pertinent part:

Member was [REDACTED] at the time of the visit. Member has a lot of [REDACTED]. [REDACTED]. Member was able to answer correctly the memory questions.

Member needs total assistance for [REDACTED]. [REDACTED]. Member needs extensive assistance for [REDACTED]. [REDACTED] assists with [REDACTED]. [REDACTED]

Member stated [REDACTED] is not receiving any therapy at this time.

Member needs supervision, but only because [REDACTED]. Member denied any [REDACTED].

Caregiver stated that member has [REDACTED]. No changes were reported.

8. On May 11, 2023, Respondent issued a Notice of Adverse Benefit Determinations (“NABDs”) reducing Petitioner’s personal care service hours from thirty (30) to twenty-seven (27) hours per week. *Id.* at 52 – 58. The NABD explained the basis of the 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: This decision was based on medical necessity (as defined by Agency for Health Care Administration’s Medical Necessity as defined in Rule 59-G, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: T1019 -Personal Care Services are reduced from 30 hours per week to 27 hours per week effective 05/22/2023 by the Medical Director because the service is not medically necessary. You are already receiving

other services that should meet your needs. You are going to receive 30 hours of home care assistance per week, based on Care Plan Reviewed and your current needs. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare’s approved review criteria and guidelines.

...

Id. at 52 – 53.

9. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated June 21, 2023, upholding the termination of five (5) hours per week of adult companion care services, upholding the reduction of homemaker services from eight (8) hours per week to five (5) hours per week, and upholding the reduction of personal care services from thirty (30) hours per week to twenty-seven (27) hours per week. *Id.* at 88 – 92. The NPAR states in pertinent part:

On March 24, 2023, we received your timely plan appeal request regarding Molina Healthcare of Florida’s Notice of Adverse Benefit Determination (NABD) dated May 11, 2023, NABD Number LTC2223800424, terminating the 5 hours a week of Adult Companion Care, reducing the 8 hours a week of Homemaker Services and the 30 hours a week of Personal Care Services to [Petitioner].

On June 21, 2023, after consideration of the information you provided to Molina Healthcare of Florida in support of your plan appeal, Molina Healthcare of Florida denies your plan appeal. As a result, [Petitioner] will not receive the 5 hours a week of Adult Companion Care, the extra 5 hours a week of Homemaker Services, and the extra 3 hours a week of Personal Care Services, effective June 21, 2023. The decision was made by a Molina Healthcare of Florida Medical Director, a Board Certified Family Medicine Physician.

We made our decision based on the Florida Agency for Health Care Administration’s Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member’s care. A significant (big) change may involve a change in the member’s state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care. You are already receiving services that should

meet your needs. For this reason, the request for the 5 hours a week of Adult Companion Care, the extra 5 hours a week of Homemaker Services, and the extra 3 hours a week of Personal Care Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the 5 hours a week of Adult Companion Care, the extra 5 hours a week of Homemaker Services, and the extra 3 hours a week of Personal Care Services, you are already receiving services that should meet your needs. You will still receive 3 hours a week of Homemaker Services and 27 hours a week of Personal Care Services.

...

RCE 1 at 88 – 89.

10. Petitioner requested a Fair Hearing due to the termination of adult companion care services, reduction of homemaker services, and reduction of personal care services. On August 21, 2023, the undersigned scheduled the Fair Hearing for June 29, 2023, at 1:00 p.m., and all parties were duly notified.

11. Ms. Cruz, a witness for Respondent, testified as follows:

- a. Ms. Cruz is a Registered Nurse. The final decision is reviewed and taken by a medical director.
- b. Petitioner suffers from multiple conditions. Petitioner is wheelchair bound.
- c. As per the 701b, Petitioner does not have [REDACTED]. See RCE 1 at 35.
- d. Petitioner requires moderate to maximum assistance with [REDACTED] ADLS and IADLs. See RCE 1 at 7 – 8.
- e. Petitioner's caregiver [REDACTED] provides twelve (12) hours per day of services to Petitioner. See RCE 1 at 36.

- f. Petitioner's needs are met at home with the twenty-eight (28) hours per week of care services. Petitioner's services were adjusted accordingly based on the 701B Assessment.
 - g. Petitioner's caregivers assist Petitioner with [REDACTED] ADLs and IADLs. See RCE 1 at 22 – 32.
 - h. Petitioner's services were reduced and terminated based on medical necessity.
 - i. Services were approved and reviewed according to Florida Administrative Code 59G that states services must be approved in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider and must be individualized based on the recipient's needs.
12. [REDACTED], Petitioner's caregiver and Authorized Representative, testified as follows:
- a. Petitioner has a [REDACTED]
[REDACTED]. Petitioner has to be turned every two (2) hours.
[REDACTED] does not know the date Petitioner's ulcer was diagnosed, but [REDACTED] thinks May or June.
 - b. Petitioner's aide leaves Petitioner in a wheelchair at the end of the aide's hours.
 - c. Petitioner weighs less than [REDACTED], is [REDACTED], and [REDACTED].
 - d. [REDACTED] is out of the home from 8:00 a.m. to 6:00 p.m. and works forty (40) hours per week. [REDACTED] no longer works on Saturdays. Petitioner's aide is with Petitioner from 9:00 a.m. to 2:00 p.m. Monday through Friday. Petitioner is alone Monday through Friday from 2:00 p.m. to 6:00 p.m. When Petitioner is with the

Patient's health condition cause [redacted] to be incapacitated, [redacted] needs a person at all times that help [redacted] with [redacted] ADL and I highly recommended that [redacted] needs more hours since [redacted] health condition and physically had worsened.

...

PCE 1 at 2.

14. As of the date of the hearing, September 5, 2023, Petitioner is authorized to receive three (3) hours per week of homemaker services and twenty-seven (27) hours of personal care services.

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. This order is the final administrative decision of AHCA under section 409.285(2)(a).

16. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C.").

17. The burden of proof in this proceeding is governed by Rule 59G-1.100(17)(g), F.A.C., 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.

18. Because Respondent is terminating and reducing previously authorized services, Rule 59G-1.100(17)(g), F.A.C., assigns the burden of proof to the Respondent regarding the termination of adult companion care services, reduction of homemaker services, and reduction of personal care services. 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.).

19. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”) (“SMMC LTC Policy”). The Agency’s SMMC LTC Policy has been incorporated, by reference, into Rule 59G-4.192, F.A.C. The SMMC LTC Policy provides 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.

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

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 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.

...

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.

...

4.2.1.9 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.

RCE 1, SMMC LTC Policy, at 95 – 102.

20. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Rule 59G-1.010, F.A.C, defines “medical necessity” as follows:

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.

Definitions Policy at 7.

A. Reduction of Homemaker Services

21. The evidence admitted and testimony presented in this case established that Respondent reduced Petitioner’s homemaker services from eight (8) hours per week to three (3) hours per

week based on medical necessity. Specifically, Respondent made its medical necessity determination based on the 701B, Petitioner’s needs, and the status of Petitioner’s caregiver. *See supra* ¶¶ 5 – 9, 11. Respondent referred to the SMMC LTC Policy, Rule 59G-4.192, F.A.C., and the Molina Clinical Policy for Medically Necessary Services (332) in making its decision. *See supra* ¶¶ 8 – 9, 11.

22. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 19. Section 4.2.1.9 of the SMMC LTC Policy defines homemaker services as 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.” *See supra* ¶ 19. The SMMC LTC Policy covers homemaker services that are determined to be medically necessary and must meet the medical necessity criteria defined in section 1.3.14 of the SMMC LTC Policy. *See supra* ¶ 19.

23. The definition of homemaker services most closely aligns with IALD tasks. Petitioner’s 701B Assessment, which was completed with input from [REDACTED], indicates that Petitioner needs total assistance (cannot do at all) with [REDACTED]; and Petitioner needs assistance (but not total help) with [REDACTED]. *See supra* ¶ 6. [REDACTED]

testified that Petitioner is alone Monday through Friday from 2:00 p.m. to 6:00 p.m. *See supra* ¶ 12.

Respondent testified that [REDACTED] provides twelve (12) hours per day of services to

Petitioner. *See supra* ¶ 11. The evidence admitted and testimony presented in this case established that Respondent reduced Petitioner’s homemaker services from eight (8) hours per week to three (3) hours per week based on medical necessity. *See supra* ¶¶ 5 – 9, 11. Respondent presented testimony and evidence to support such a determination, stating that Petitioner’s needs are met by [REDACTED] approved services. *See supra* ¶ 11. Respondent presented testimony and evidence that Petitioner’s caregiver, [REDACTED], is able to assist Petitioner with [REDACTED] ADLs and IADLs. Respondent presented testimony and evidence to quantify the amount of natural support that Petitioner currently receives from [REDACTED]. *See supra* ¶ 11. [REDACTED] did not present testimony or evidence to the contrary. In fact, [REDACTED] testified that [REDACTED] no longer works on Saturdays. *See supra* ¶ 12. Given that the eight (8) hours per week of homemaker services are existing services, Respondent bears the burden of presenting evidence or testimony fully illustrating Petitioner’s lack of need. The undersigned finds that Respondent’s evidence and testimony is persuasive and convincing for the aforementioned reasons. Respondent demonstrated through testimony and evidence that Petitioner’s continued homemaker needs can be met by the approved homemaker services and natural support of [REDACTED] caregiver. Petitioner’s position is that Petitioner’s health has declined and that all of the previously authorized homemaker services are needed. *See supra* ¶ 12. However, according to the 701B, Petitioner always has assistance with all of [REDACTED] IADLs, except for [REDACTED], and neither Petitioner nor [REDACTED] provided persuasive or convincing testimony or evidence to suggest that Petitioner’s medical deterioration prevents [REDACTED] from performing IADLs [REDACTED] currently performs. Further, neither Petitioner nor [REDACTED] provided persuasive or convincing testimony or evidence to suggest that [REDACTED] can no longer assist Petitioner with general household

activities and routine household care. Upon consideration of the aforementioned facts, Respondent has established that the eight (8) hours of homemaker services are in excess of Petitioner's needs. Thus, Petitioner's previously approved level of homemaker services no longer meet the LTC Policy's criteria for medical necessity regarding homemaker services. See supra ¶ 7.

24. Petitioner's physician provided a letter stating needs a person at all times that helps ■■■ with ■■■ ADLs and recommending that Petitioner needs more hours since ■■■ health condition and physically had worsened. However, the fact that a provider prescribed, recommended, or approved medical or allied care, goods, or services does not, itself, make such care, goods, or services medically necessary or a medical necessity or a covered service. See supra ¶ 20.

25. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned finds that Respondent has met the burden of proving that the reduction of Petitioner's homemaker services from eight (8) hours per week to three (3) hours per week is warranted due to lack of medical necessity. Accordingly, the undersigned Hearing Officer concludes that Respondent did prove by a preponderance of the evidence that Respondent's reduction of homemaker services was correct.

B. Reduction of Personal Care Services

26. The evidence admitted and testimony presented in this case established that Respondent reduced Petitioner's personal care services from thirty (30) hours per week to twenty-seven (27) hours per week based on medical necessity. Specifically, Respondent made its medical necessity determination based on the 701B, Petitioner's needs, and the status of Petitioner's caregiver. See supra ¶¶ 5 – 9, 11. Respondent referred to the SMMC LTC Policy, Rule 59G-4.192, F.A.C., and the

Molina Clinical Policy for Medically Necessary Services (332) in making its decision. *See supra* ¶¶ 8 – 9, 11.

27. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 19. Further, in order to receive LTC services, services must be documented on an individual plan of care based upon a comprehensive needs assessment. *See supra* ¶ 19. The comprehensive assessment includes the completion of the 701B Comprehensive Assessment and the LTC Supplemental Assessment. *See supra* ¶ 19. Section 4.2.2.6 of the SMMC LTC Policy states personal care services are 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.” *See supra* ¶ 19. The record reflects that Petitioner lives with [REDACTED]. *See supra* ¶ 2. With regard to ADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED]. [REDACTED] needs assistance (but not total help) with [REDACTED]; and uses [REDACTED]. *See supra* ¶ 5. The 701B Assessment states that Petitioner always has assistance with [REDACTED], and that Petitioner has assistance most of the time with [REDACTED]. *See supra* ¶ 5. With regard to IADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED]. [REDACTED]. *Id.* at 8. Petitioner needs assistance (but not total help) with [REDACTED]. [REDACTED]. *See supra* ¶ 6. The 701B Assessment states that Petitioner always has assistance

with [REDACTED]
[REDACTED], and that Petitioner has assistance most of the time with [REDACTED]. See supra ¶ 6. Petitioner currently receives twenty-seven (27) hours of personal care services and three (3) hours of homemaker services each week, for a total of thirty (30) hours of care. See supra ¶ 7 and 8.

28. As Respondent bears the burden of proof, Respondent must show that the previously approved level of personal care services are no longer medically necessary. Appendix 9.1 of the Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“PCS Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, provides general guidance concerning the time allotted for personal care tasks. On behalf of Respondent, [REDACTED] testified that Petitioner’s needs are met with [REDACTED] currently approved services. See supra ¶ 11. However, [REDACTED] testified that Petitioner requires more assistance for [REDACTED] ADLs and IADLs because Petitioner’s condition has deteriorated, namely Petitioner has developed [REDACTED]. See supra ¶ 12.

29. The record does not support a reduction. For example, Petitioner’s condition has not improved – here, Petitioner’s condition is “about the same” as it was this time last year. See supra ¶ 4. Thus, logically, Petitioner should continue to receive the same level of care as in the previous authorization period. Respondent failed to provide any testimony or evidence to show that Petitioner requires less assistance with [REDACTED] ADLs or IADLs, or that [REDACTED] is able to provide more assistance with Petitioner’s ADLs or IADLs as [REDACTED] caregiver. Based on the foregoing, Respondent did not demonstrate that Petitioner’s previous amount of personal care was in excess of [REDACTED] needs, and thus not medically necessary.

30. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Respondent failed to meet its burden of proving that Respondent reduced Petitioner's personal care services from thirty (30) hours per week to twenty-seven (27) hours per week based on medical necessity. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that Respondent's reduction of personal care services was correct.

C. Termination of Adult Companion Care Services

31. The evidence admitted and testimony presented in this case established that Respondent terminated Petitioner's adult companion care services of five (5) hours per week based on medical necessity. Specifically, Respondent made its medical necessity determination based on the 701B, Petitioner's needs, and the status of Petitioner's caregiver. *See supra* ¶¶ 5 – 9, 11. Respondent referred to the SMMC LTC Policy, Rule 59G-4.192, F.A.C., and the Molina Clinical Policy for Medically Necessary Services (332) in making its decision. *See supra* ¶¶ 8 – 9, 11.

32. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 19. Section 4.2.1.1 of the SMMC LTC Policy defines adult companion care services as 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." *See supra* ¶ 19. The SMMC LTC Policy covers adult

companion care services that are determined to be medically necessary and must meet the medical necessity criteria defined in section 1.3.14 of the SMMC LTC Policy. *See supra* ¶ 19.

33. As Respondent bears the burden of proof, Respondent must show that it is not medically necessary for Petitioner to receive the terminated adult companion care service hours. To be medically necessary, adult companion care services must meet the criteria set forth in section 1.3.14(b) of the SMMC LTC Policy. *See supra* ¶ 19. The record indicates that Respondent has shown that the five (5) hours per week of adult companion care services are in excess of Petitioner's needs at this time. Petitioner lives with [REDACTED]. *See supra* ¶ 2. [REDACTED] did not testify that she has minimized [REDACTED] natural support provided to Petitioner. In fact, [REDACTED] stated on the 701B that [REDACTED] was very confident in [REDACTED] ability to continue to provide care for Petitioner. *See supra* ¶ 12. On behalf of Respondent, [REDACTED] testified that Petitioner's needs are met with [REDACTED] currently approved services. *See supra* ¶ 11. Although the 701B states Petitioner does not need supervision, the notes and summary section of the 701B Assessment states Petitioner needs supervision only because [REDACTED] suffers from vision loss and limited mobility. *See supra* ¶ 7. [REDACTED] testified that when Petitioner is with the home health aide on Saturdays for four (4) hours, [REDACTED] uses this time to run errands. *See supra* ¶ 12. Respondent did not dispute that Petitioner requires supervision, but asserted that [REDACTED] provides twelve (12) hours per day of services to Petitioner. *See supra* ¶ 11. Respondent provided credible and convincing evidence that Petitioner's adult companion needs can be met through the natural support of [REDACTED] caregiver. The record does not indicate that Petitioner is socially isolated at this time. Based on the record, Respondent has demonstrated that the five (5) hours per week of adult companion care services are in excess of Petitioner's needs at this

time. Further, through [REDACTED] own testimony, the record indicates that these services were primarily furnished for the convenience of Petitioner's caregiver, for running errands on Saturdays, and not based on the medical needs of Petitioner. Thus, Petitioner no longer meets the LTC Policy's criteria for medical necessity regarding adult companion care services. Respondent has shown that Petitioner's five (5) hours of adult companion care services no longer meet 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.*** (Emphasis added.)

34. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned finds that Respondent has met the burden of proving that the termination of five (5) hours per week of adult companion care services is warranted due to lack of medical necessity. Accordingly, the undersigned Hearing Officer concludes that Respondent did prove by a preponderance of the evidence that Respondent's termination of adult companion care services was correct.


IT IS THEREFORE ORDERED AND ADJUDGED THAT:

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

Respondent's reduction of Petitioner's personal care services is **REVERSED**. Petitioner's appeal based on Respondent's reduction of personal care services is **GRANTED**.

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

DONE AND ORDERED this 25th day of September, 2023 in Tallahassee, Leon County, Florida.

 Kameisha Presley
23-FH1715
2023.09.25
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KAMEISHA PRESLEY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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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