

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



FILED

Sep 27, 2023, 10:47 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1822

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1823

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on September 21, 2023, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Yuneisy Cruz
Dir. of Healthcare Services., Long Term Care Program
Molina Health Care of Florida, Inc.

STATEMENT OF ISSUE

The first issue is whether the Respondent proved by a preponderance of the evidence that the reduction of three (3) hours of personal care services per week for the Petitioner (Case No. 23-FH1822) was correct.

The second issue is whether the Respondent proved by a preponderance of the evidence that the reduction of three (3) hours of homemaker services per week for the Petitioner (Case No. 23-FH1823) was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] the Petitioner's [REDACTED] and designated Authorized Representative appeared on behalf of the Petitioner. The Petitioner also appeared at the Fair Hearing. A Haitian-Creole translator, Samy, Identification Number MN341, provided translation services at the Fair Hearing.

Yuneisy Cruz, ("Ms. Cruz"), Molina Health Care of Florida, Inc., ("Molina"), Director of Healthcare Service for Long Term Care appeared for the hearing, provided testimony, and represented Respondent. Gabriel Novoa, M.D. ("Dr. Novoa") Molina Medical Director, provided testimony on behalf of the Respondent. Caridad Bello, Government Contracts Specialist and Mariana Nunez, Grievance and Appeals Lead, also appeared at the Fair Hearing on behalf of Molina.

Leanne Williams, Medical Healthcare Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared at the Fair Hearing for observational purposes.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and three (103)-page evidence packet that was admitted into evidence without

objection, is identified herein as “Respondent’s Composite Exhibit 1”, and is recorded in the OFH document management system and designated as follows: “MFH Office Packet.pdf”.

FINDINGS OF FACT

1. The Petitioner is an enrolled member of Molina’s LTC plan. See Respondent’s Composite Exhibit 1, page 29. Molina is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. The Petitioner is an [REDACTED] who lives in [REDACTED] with [REDACTED]. See Respondent’s Composite Exhibit 1, pages 11 and 20. *Testimony of* [REDACTED].

3. The Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, page 12. In addition, the Authorized Representative testified that the Petitioner has been recently diagnosed with [REDACTED]. *Testimony of [REDACTED]*. The Petitioner was [REDACTED]. [REDACTED]. See Respondent's Composite Exhibit 1, page 12. Finally, the Petitioner is found to have [REDACTED] *Id.*

4. The most recent Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), admitted into evidence is dated April 18, 2023, reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). The Petitioner needs some assistance but not total help with [REDACTED]. See Respondent's Composite Exhibit 1, page 14. The April 18, 2023, 701B further reflects the Petitioner requires supervision and prompts for [REDACTED]. *Id.* Finally, the April 18, 701B also states the Petitioner uses assistive devices for [REDACTED]
[REDACTED]

5. The Petitioner testified that [REDACTED] health has considerably declined since the April 18, 2023, 701B, and because of [REDACTED]
[REDACTED] now requires total assistance with [REDACTED]
[REDACTED]. In addition, currently [REDACTED] cannot stand more than five (5) minutes, cannot walk as far as [REDACTED] could in April of 2023, and although [REDACTED] can eat without

assistance, requires supervision, and total assistance to set-up the food before [REDACTED] *Testimony of [REDACTED]*.

6. Regarding the Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the April 18, 2023, 701B reflects the Petitioner needs total assistance (cannot do at all) with [REDACTED] [REDACTED] See Respondent’s Composite Exhibit 1, page 15. The April 18, 2023, 701B further reflects the Petitioner needs assistance (but not total help) with [REDACTED] [REDACTED], but the Petitioner has testified that since the April 18, 2023, 701B assessment was completed, [REDACTED] now requires total assistance with [REDACTED] [REDACTED] and that [REDACTED] personal hygiene takes longer. *Id* and [REDACTED] *Testimony*. The April 18, 2023, 701 reflects Petitioner uses assistive devices for [REDACTED] but the Petitioner has testified that since the 701B assessment was completed, [REDACTED] now requires total assistance with [REDACTED]. *Id*.

7. Petitioner is currently authorized to receive the following home and community-based services: eighteen (18) hours per week of personal care services per week and seven (7) hours per week of homemaker services. See Respondent’s Composite Exhibit 1, pages 47, 56, and 72. *Testimony of Ms. Cruz*.

8. On June 5, 2023, the Respondent issued a Notice of Adverse Benefit Determination (“NABD”) in Case Number 23-FH1822 reducing the Petitioner’s personal care hours from twenty-one (21) hours per week to eighteen (18) hours per week. See Respondent’s Composite Exhibit

1, pages 46-51. In their NABD reducing the Petitioner's personal care hours three (3) hours per week, the Respondent stated the reason for their determination as follows:

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

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

Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and 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 requested service is not a covered benefit.

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 59G-4, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: There is a reduction Effective 06/18/2023 of personal care services from 21 hours to 18 hours per week by the Medical Director because the additional services are not medically necessary. You are already receiving other services that should meet your needs. You are going to receive 25 hours of HHA assistance with these new changes. 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.

9. On June 5, 2023, the Respondent issued a Notice of Adverse Benefit Determination (“NABD”) in Case Number 23-FH1823 reducing the Petitioner’s homemaker hours from ten (10) to (7) hours per week. See Respondent’s Composite Exhibit 1, pages 54-61. In their NABD reducing the Petitioner’s homemaker hours, the Respondent stated the reason for their determination as follows:

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

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

Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and 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 requested service is not a covered benefit.

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 59G-4, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: There is a reduction Effective 06/18/2023 of Homemaker services from 10 hours to 7 hours per week by the Medical Director because the additional services are not medically necessary. You are already receiving other services that should meet your needs. You are going to receive 25 hours of HHA assistance with these new changes. 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.

10. The Petitioner timely requested an appeal of Respondent's reduction of the personal care and homemaker hours per week and on July 5, 2023, Respondent sent Petitioner a Notice of Plan Appeal Resolution letter ("NPAR"), upholding the reduction of three (3) hours of personal care services per week (Case Number 23-1822) and the reduction of three (3) hours of homemaker services per week (Case Number 23-1823). See Respondent's Composite Exhibit 1, pages 64-69.

The NPAR stated as follows:

On June 15, 2023 we received your timely plan appeal request regarding Molina Healthcare of Florida's Notice of Adverse Benefit Determination (NABD) dated June 5, 2023, NABD Number LTC2226301313, reducing the 10 hours a week of Homemaker Services and the 21 hours a week of Personal Care Services to [Petitioner].

On July 5, 2023, after consideration of the information you provided to Molina Healthcare of Florida in support of your plan appeal, Molina Healthcare of Florida hereby denies your plan appeal. As a result, [Petitioner] will not receive the extra 3 hours a week of Homemaker Services and the extra 3 hours a week of Personal Care Services, effective July 5, 2023. The decision was made by a Molina Healthcare Appeals and Grievance, Associate Specialist.

Id.

11. The Petitioner requested a Fair Hearing due to the reduction of three (3) hours of personal care services per week and a reduction of three (3) hours of homemaker services per week. The undersigned scheduled the Fair Hearing which occurred on September 21, 2023, at 10:00 a.m. EST.

12. During the Fair Hearing, the Petitioner's Authorized Representative testified [REDACTED] health has declined, that [REDACTED] is overwhelmed when [REDACTED] left alone, that [REDACTED] ability to stand, walk and mobility has decreased, and that [REDACTED] ability to perform [REDACTED] ADLs has changed since the April 18, 2023, 701B assessment admitted into evidence in this matter. The Authorized Representative testified that [REDACTED] works full-time Monday through Friday, leaving the house at 7:00 a.m. and returning at 6:00 p.m. and works full-time at least two (2) weekends per month, that [REDACTED] works full-time out of the home between eight (8) to ten (10) hours per day, six (6) to seven (7) days per week, and that [REDACTED] and bedridden [REDACTED] are often alone at home. *See also* Respondent's Composite Exhibit 1, page. 29. The Authorized Representative also testified that [REDACTED] requires total assistance with using the bathroom, is bladder incontinent between ten (10) to twelve (12) times per day and cannot change her soiled undergarments without help. [REDACTED] testified [REDACTED] must wait until [REDACTED] returns from work to be cleaned and provided clean undergarments when [REDACTED] is incontinent. In addition, [REDACTED] testified [REDACTED] condition is worse, requires constant attention, and that [REDACTED] is afraid to leave [REDACTED] alone at home. Finally, the Authorized Representative testified that with [REDACTED] declining health and injured shoulders, that it takes considerably longer to complete [REDACTED] ADLs, and [REDACTED] ability to

perform ■ IADLs than what is reflected in the Respondent's May 31, 2023, Functional Needs Assessment. See Respondent's Composite Exhibit 1, pages 30 – 43.

13. Ms. Cruz testified for the Respondent that based on the Functional Needs Assessment and the Petitioner's April 18, 2023, 701B, the Petitioner's needs are met and the reductions in personal care and homemaker hours were correct. Dr. Novoa testified that he did not review any updated medical records for the Petitioner, and that based on the April 18, 2023, 701B and the definition of medical necessity in Rule 59G-1.010, FAC, the reduction of the Petitioner's personal care and homemaker hours were correct.

CONCLUSIONS OF LAW

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

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

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

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

17. Because the Respondent is reducing existing services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent to demonstrate their decisions were

correct. 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 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 Florida Administrative Code Rule 59G-4.192. 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:

...

4.2.1.9 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.

...

4.2.1.14 Personal Emergency Response Systems

For installation and service monitoring of an electronic device connected to an enrollee’s phone that includes a portable “help” button, when provided to an enrollee at high risk of institutionalization to secure help in an emergency.

...

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.

...

6.0 Documentation

...

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.

SMMC LTC Policy, pages 1-8.

19. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medical necessity” as 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.

20. The Agency’s Florida Medicaid Personal Care Services Coverage Policy, November 2016 (“PC Policy”) has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.215. The PC Policy provides as follows:

1.1 Description

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician’s order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

...

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities – Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient's needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
Grooming and Skin Care	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated

Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy, pages 3 – 8, and 10.

21. In the instant case, Respondent reduced the Petitioner’s personal care services by three (3) hours per week and the Petitioner’s homemaker services three (3) hours per week. *See supra* ¶ 8, 9 and 10. As established on the record by the evidence and testimony, Respondent reduced the Petitioner’s personal care and homemaker hours because the additional hours were not medically necessary. *See supra* ¶ 8 and 9.

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* ¶ 18.

REDUCTION OF PERSONAL CARE HOURS

23. The evidence presented in this case does not reflect that the Respondent’s decision to reduce the Petitioner’s personal care service three (3) hours per week was correct. Specifically, Petitioner lives in a residence with [REDACTED] who both work full-time outside of the home, and the Petitioner is frequently left alone. See supra ¶ 12. Regarding ADLs, Petitioner needs total assistance with [REDACTED] [REDACTED] requiring supervision, and total assistance to set-up the food before because of increasing [REDACTED] [REDACTED]. See supra ¶ 5. This level of assistance is greater than that reflected in the most recent April 18, 2023, 701B admitted into evidence and is reflective of the Petitioner’s decline in health. See supra ¶¶ 4, 5, and 12. Regarding the Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the April 18, 2023, 701B reflects the Petitioner needs total assistance (cannot do at all) with [REDACTED], but the Petitioner has testified that since the April 18, 2023, 701B assessment was completed, [REDACTED] now requires total assistance with [REDACTED] and that [REDACTED] personal hygiene takes longer. See supra ¶ 6. The April 18, 2023, 701B further reflects the Petitioner needs assistance (but not total help) with [REDACTED] [REDACTED]. *Id.* The Petitioner has multiple serious medical conditions, including [REDACTED], which requires constant attention and creates fear in the Petitioner’s [REDACTED] when [REDACTED] is left home alone. See supra ¶¶ 3 and 12.

24. Section 1.3.14 of the SMMC LTC Policy mandates that the requested services must “[b]e 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", not for the convenience of the recipient, and enable the enrollee to have access to live in the setting of his or her choice. See supra ¶ 18. Here, the Petitioner is currently authorized to receive the eighteen (18) hours of personal care services per week. See supra ¶ 7. Petitioner's currently authorized personal care services are "[t]o provide assistance with ADLs which are incidental to the care furnished or are essential to the health and welfare of the enrollee." See supra ¶ 19. The Authorized Representative has established that the Petitioner's health has declined and that [REDACTED] requires a greater level of assistance in performing [REDACTED] ADLs than that reflected in the April 18, 2023, 701B Assessment. See supra ¶ ¶ 4, 5, and 12. Given the fact that the Petitioner's health has significantly declined since the April 18, 2023, 701B Assessment admitted into evidence, has diabetes that requires constant attention, and that [REDACTED] is left alone Mondays through Fridays and sometimes on weekends, the Respondent has not established that a three (3) hour reduction of personal care services per week is sufficient to meet the Petitioner's needs, that the reduction of personal care hours is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and in excess of the patient's needs, is for the convenience of the recipient, and enables the enrollee to have access to live in the setting of [REDACTED] choice. See supra ¶ ¶ 18, 19, 20 and 22.

25. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, the Respondent failed to prove by a preponderance of the evidence that a reduction of three (3) hours per week of personal care services was correct." See supra ¶ ¶ 18, 19, 20 and 22.

26. In light of the testimony and evidence in this matter, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent failed to meet their burden of proving that a reduction of three (3) hours personal care services per week were not medically necessary. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that their reduction of three (3) hours of personal care services per week was correct.

REDUCTION OF HOMEMAKER SERVICES

27. The evidence presented in this case does not reflect that the Respondent's decision to reduce the Petitioner's homemaker services three (3) hours per week was correct. Specifically, Petitioner lives in a residence with [REDACTED] who both work full-time outside of the home, and the Petitioner is frequently left alone. See supra ¶ 12. Regarding ADLs, Petitioner needs total assistance with because of [REDACTED] [REDACTED] now requires total assistance with [REDACTED] [REDACTED] without assistance, requiring supervision, and total assistance to set-up the food before [REDACTED]. This level of assistance is greater than that reflected in the most recent April 18, 2023, 701B admitted into evidence and is reflective of the Petitioner's decline in health. See supra ¶¶ 4, 5, and 12. Regarding the Petitioner's Instrumental Activities of Daily Living ("IADLs"), the April 18, 2023, 701B reflects the Petitioner needs total assistance (cannot do at all) with [REDACTED] [REDACTED], but the Petitioner has testified that since the 701B assessment was completed, [REDACTED] now requires total assistance with [REDACTED] [REDACTED], and that [REDACTED] personal hygiene takes longer. See supra ¶¶ 6 and 12. The

April 18, 2023, 701B further reflects the Petitioner needs assistance (but not total help) with [REDACTED], and requires no assistance with [REDACTED].

Id. The Petitioner has multiple serious medical conditions, including [REDACTED] which requires constant attention and creates fear in the Petitioner's [REDACTED] when [REDACTED] is left home alone. *See supra* ¶¶ 3 and 12.

28. Section 1.3.14 of the SMMC LTC Policy mandates that the requested services must “[b]e 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”, not for the convenience of the recipient, and enable the enrollee to have access to live in the setting of his or her choice. *See supra* ¶ 18. Here, the Petitioner is currently authorized to receive the seven (7) hours of homemaker services per week. *See supra* ¶ 7. Petitioner’s currently authorized homemaker care services are to provide assistance with general household activities (such as meal preparation), routine household care (including laundry and pest control) by a trained homemaker, and personal hygiene when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. *See supra* ¶ 18. The Authorized Representative has established that the Petitioner’s health has declined and that [REDACTED] requires a greater level of assistance in performing [REDACTED] ADLs and IADLs than that reflected in the April 18, 2023, 701B Assessment. *See supra* ¶¶ 4, 5, and 12. Given the fact that the Petitioner’s health has significantly declined since the April 18, 2023, 701B Assessment admitted into evidence, has diabetes that requires constant attention, and that [REDACTED] is left alone Mondays through Fridays and sometimes on weekends, the Respondent has not established that a three (3) hour reduction of homemaker services per week is sufficient to meet her needs, that the reduction of homemaker

hours is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and in excess of the patient's needs, is for the convenience of the recipient, and enables the enrollee to have access to live in the setting of [REDACTED] choice. See supra ¶¶ 18, 19, and 22. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, the Respondent failed to prove by a preponderance of the evidence that a reduction of three (3) hours per week of homemaker services was correct." See supra ¶¶ 18, 19 and 22.

29. In light of the testimony and evidence in this matter, the SMMC LTC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent failed to meet their burden of proving that a reduction of three (3) hours of homemaker services per week were not medically necessary. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that their reduction of three (3) hours of homemaker services per week was correct.

DECISION

Respondent's reduction of three (3) hours of personal care services per week (Case No. 23-FH1822) is **REVERSED**. Petitioner's appeal based on Respondent's reduction of three (3) hours of personal care services per week is **APPROVED**.

Respondent's reduction of three (3) hours of homemaker services per week (Case No. 23-FH1823) is **REVERSED**. Petitioner's appeal based on Respondent's reduction of three (3) hours of homemaker services per week is **APPROVED**.

DONE AND ORDERED this 27th day of September, 2023, in Tallahassee, Leon County,
Florida.

Alan J. Leifer
23-FH1822 & 23-
Alan J. Leifer FH1823
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ALAN J. LEIFER, 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:

[REDACTED]

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