

also provided testimony on Petitioner's behalf. Petitioner appeared at the hearing, but did not provide testimony.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine"), appeared for the hearing and represented Respondent. Dr. John Carter ("Dr. Carter"), Long Term Care ("LTC") Medical Director for Sunshine, provided testimony on behalf of the Respondent. The following individuals also appeared on behalf of Respondent, but did not provide testimony: Jetzabel Rodriguez, Care Coordinator for Sunshine; Solange Luna, LTC Supervisor for Sunshine; and Christian Pacheco, Senior Director of Quality Improvement for Sunshine.

Lisa Sanchez, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes. Interpreter Magaly with CyraCom, appeared for the hearing and provided translation services on behalf of Petitioner's Authorized Representative.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 23-page evidence packet. The packet consisted of a 23-page facsimile transmission from [REDACTED] to the Office of Fair Hearings, dated July 22, 2020. Absent an objection from Respondent, the Hearing Officer admitted Respondent's evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 114-page evidence packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; a Medicaid Fair Hearing Summary, dated July 10, 2020; a Notice of Adverse Benefit Determination ("NABD"), dated March 12, 2020; Sunshine's care plan, signed by the Care Manager on March 11, 2020; the care plan, signed by the Care Manager on July 6, 2020; the

Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of March 5, 2020 (the “3/5/20 701B”); the 701B with an assessment date of June 1, 2020 (the “6/1/20 701B”); an envelope to Sunshine, marked as received on March 26, 2020; the completed Request for an Appeal or Grievance Form, dated March 24, 2020; Sunshine’s Standard Appeal Acknowledgment, dated March 30, 2020; the Notice of Plan Appeal Resolution (“NPAR”), dated April 23, 2020; the Sunshine Health Policy and Procedure LT.UM.09; and Fla. Admin. Code R. 59G-1.010. Absent an objection from Petitioner, the undersigned admitted Respondent’s 114-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s LTC plan. *See* Respondent’s Composite Exhibit 1, page 2. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is a widowed, adult female who resides in a private residence. *See* Respondent’s Composite Exhibit 1, page 49. The 6/1/20 701B, which is the most recent 701B, reflects that Petitioner has the following health conditions: allergies; arthritis; high blood pressure; high cholesterol; frequent bladder incontinence; osteoporosis; depression; and Alzheimer’s disease. *See* Respondent’s Composite Exhibit 1, pages 55 – 56. The medical records for Petitioner’s ██████████ 2020, office visit with ██████████, Advanced Registered Nurse Practitioner (“ARNP”) (“the ██████████/20 office visit note”), reflects that Petitioner has impaired memory, poor concentration, “poor understanding of conditions/impaired judgement,” and is “unable to stay focused on conversation.” Petitioner’s Composite Exhibit 1, pages 13 and 14. The

█/20 office visit note also states that Petitioner “cannot be left alone in the house” and “is at a point in time that needs 24 hour supervision.” *Id.* at 10.

3. The 6/1/20 701B reflects the following regarding Petitioner’s Activities of Daily Living (“ADLs”). Petitioner needs no assistance with eating. See Respondent’s Composite Exhibit 1, page 53. Petitioner uses assistive devices for transferring and walking/mobility. *Id.* Petitioner needs assistance (but not total help) with bathing, dressing, and using the bathroom. *Id.*

4. Regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the 6/1/20 701B reflects that Petitioner needs supervision or prompting when using the telephone. See Respondent’s Composite Exhibit 1, page 54. Petitioner needs assistance (but not total help) with shopping, managing medication, and using transportation. Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, and preparing meals. *Id.*

5. Petitioner is currently authorized to receive the following home and community-based services: 6 hours per week of in-home respite; 7 home delivered meals weekly; 12 hours weekly of personal care services; 4 hours weekly of homemaker services; pull-ups; wipes; and underpads. See Respondent’s Composite Exhibit 1, page 29.

6. On March 12, 2020, Respondent issued an NABD denying Petitioner’s request for 10 hours per week of adult companion care services. See Respondent’s Composite Exhibit 1, page 4. The NABD stated the reason for Respondent’s determination 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: The request for the addition of 6 hours per week of In Home Respite Care Services and the addition of 10 hours per week of Companion Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs.

The member's present care plan includes

- 12 hours per week of Personal Care Services
- 4 hours per week of Homemaker Services
- 7 meals per week of Home Delivered Meals

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

Respondent's Composite Exhibit 1, pages 4 – 5.

7. Petitioner requested an appeal of Respondent's denial. See Respondent's Composite Exhibit 1, page 69. On April 23, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 76. The NPAR stated as follows:

On March 26, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated March 12, 2020, Notice of Adverse Benefit Determination Number [REDACTED], denying, the respite care 6 hours per week (the care given at your home to give your care giver a break) additional 10 hours per week of companion care (the person who helps and watches over you) provided to [Petitioner].

On April 21, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby denies your plan appeal. As a result, [Petitioner] will not receive the respite care 6 hours per week, additional 10 hours per week of companion care effective April 21, 2020.

The reason for our decision was:

The reconsideration of the request for the addition of 10 hours per week of companion care, and 6 hours per week of In Home Respite Care Services is denied for lack of medical necessity.

Original denial is upheld. Based on the assessment, **the member's currently approved services are adequate to meet the member's care needs. There have been no changes in the member's living situation recently.** The member's present care plan includes: 12 hours per week of Personal Care Services, 4 hours per week of Homemaker Services, and 7 meals per week of Home Delivered Meals. Adult Day Care could be considered to ensure the member's safety while the caregiver works. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

This decision was made by a Medical Director who is Board Certified Physician Cardiologist.

Respondent's Composite Exhibit 1, page 76. (Emphasis added.)

8. On June 23, 2020, [REDACTED] requested a Fair Hearing due to the denial of adult companion care services. On July 6, 2020, the undersigned scheduled the Fair Hearing for August 5, 2020, at [REDACTED], and all parties were duly notified.

9. [REDACTED] is Petitioner's daughter. [REDACTED] resides in the home with Petitioner, and provides care to Petitioner. [REDACTED] believes that Petitioner cannot be "by herself." [REDACTED] is requesting the adult companion care services, as she ([REDACTED]) cannot run errands outside the house. Additionally, [REDACTED] is searching for a job; and at any time, she could receive a call from an employer.

10. Dr. Carter is a LTC Medical Director for Sunshine. He specializes in internal medicine, geriatric medicine, and hospice and palliative medicine. Dr. Carter explained that the request for 10 hours per week of adult companion care services was denied, as Petitioner resides in the home

with her daughter, and Petitioner receives other home and community-based services, such as 12 hours per week of personal care services, 4 hours per week of homemaker services, and 6 hours per week of respite care.

CONCLUSIONS OF LAW

11. 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).

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

13. 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.

14. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. 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.).

15. The Florida Medicaid policy that applies to the requested services is the 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:

4.2.1.1 Adult Companion Care

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

...

4.2.1.8 Home Delivered Meals

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

4.2.1.9 Homemaker Services

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

...

4.2.1.15 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.

...

6.0 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.

16. 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.

Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

17. In the instant case, Petitioner requested 10 hours of adult companion care services per week. *See supra* ¶ 6 and 7. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *Id.*

18. 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* ¶ 15. Section 4.2.1.1 of the SMMC LTC Policy reflects that adult companion care services are "[t]he 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* ¶ 15.

19. The evidence presented in this case does not reflect that Petitioner is in need of 10 hours per week of adult companion care services. Specifically, regarding ADLs, Petitioner uses assistive devices for transferring and walking/mobility, and needs assistance (but not total help) with bathing, dressing, and using the bathroom. *See supra* ¶ 3. Petitioner needs no assistance with eating. *Id.* Regarding IADLs, Petitioner needs: supervision or prompting when using the telephone; assistance (but not total help) with shopping, managing medication, and using transportation; and total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, and preparing meals. *See supra* ¶ 4. However, ██████████ resides in the home with Petitioner, and provides care to Petitioner. *See supra* ¶ 9. Petitioner also receives other home and community-based services. *See supra* ¶ 10. Although ██████████ believes that

Petitioner cannot be “by herself,” *See supra* ¶ 9, Petitioner offered no substantive testimony on how the denial of the adult companion care services will impact Petitioner’s social enrichment, or the supervision of Petitioner to protect her health, safety, and well-being. *See supra* ¶ 9 and ¶ 15. Although the record reflects that Petitioner “cannot be left alone in the house,” “is at a point in time that needs 24 hour supervision,” has impaired memory, poor concentration, “poor understanding of conditions/impaired judgement,” and is “unable to stay focused on conversation, *supra* ¶ 2, Petitioner did not explain how the 10 hours of adult companion care services will be utilized to meet Petitioner’s needs (e.g., a daily schedule, a schedule of non-medical care, supervision and social enrichment, or the amount of time needed for non-medical care, supervision and social enrichment). Considering the totality of Petitioner’s circumstances – including the fact that Petitioner resides with [REDACTED] and receives other home and community based services – Petitioner’s evidence fails to justify the approval of 10 hours of adult companion care services weekly. Based upon the evidence presented by both parties, Petitioner failed to establish that the requested adult companion care services are warranted in this case.

20. Section 1.3.14 of the SMMC LTC Policy requires 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.” *See supra* ¶ 15. It should be noted that Petitioner is currently authorized to receive the following home and community-based services: 6 hours per week of in-home respite; 7 home delivered meals weekly; 12 hours weekly of personal care services; 4 hours weekly of homemaker services; pull-ups; wipes; and underpads. *See supra* ¶ 5. The NPAR explains that Petitioner’s “currently approved services are

adequate to meet the member's care needs” and that “[t]here have been no changes in the member's living situation recently.” See supra ¶ 7. Considering the SMMC LTC Policy’s definitions for adult companion care services, homemaking services, home delivered meals, and personal care services, supra ¶ 15, Petitioner did not demonstrate that her aforementioned needs, supra ¶ 19, are not sufficiently met by her currently authorized services. Further, given that Petitioner failed to establish that the requested adult companion care services are warranted in this matter, supra ¶ 19, the requested adult companion care services are “in excess of [Petitioner’s] needs.” See supra ¶ 15.

21. The record reflects that [REDACTED] is requesting the adult companion care services, as she ([REDACTED]) cannot run errands outside the house, and she is searching for a job. See supra ¶ 9. However, section 1.3.14 of the SMMC LTC Policy requires that the requested services must “[b]e furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.” See supra ¶ 15.

Conclusion

22. In light of the both parties’ testimony, Petitioner’s Composite Exhibit 1, Respondent’s Composite Exhibit 1, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that the 10 hours per week of adult companion care services are medically necessary.

23. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested adult companion care services was incorrect.

DECISION

Respondent's denial of 10 hours of adult companion care services is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 3rd day of September, 2020, in Tallahassee, Leon County, Florida.

Tracie Hardin



20-FH [REDACTED]

2020.09.03

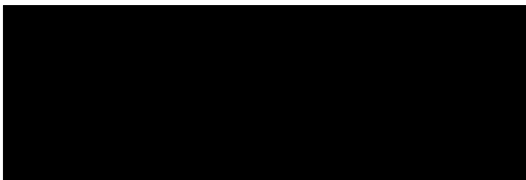
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

COPIES FURNISHED TO:



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