



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

**FILED**

Nov 03, 2020, 9:47 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Medicaid Fair Hearing in the above styled case on October 5, 2020, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Caridad Bello

Senior Specialist of Government Contracts

Molina Health Care of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of homemaker services from thirty-five (35) hours per week to five (5) hours per week was correct.

## PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and mother, appeared at the Fair Hearing and provided testimony on Petitioner’s behalf.

Caridad Bello, Senior Specialist of Government Contracts for Molina Health Care of Florida, Inc. (“Molina” or “Respondent”), represented Respondent at the hearing. Jennifer Bellina (“Ms. Bellina”), Manager of Long Term Care Case Management for Molina, provided testimony on behalf of Respondent. Katia Matos (“Ms. Matos”), Director of Health Care Services for Molina, provided testimony on behalf of Respondent. The following individuals appeared on behalf of Respondent but did not testify: Dr. Mark Blume, Chief Medical Officer for Molina; Erika Morales, Utilization Management Supervisor for Molina; and Yinetsy Brajdic, Health Care Services Supervisor for Molina.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Interpreter Fina, translator number JI203 of Global Interpreting Network, appeared for the hearing and provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the hearing. Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and six (106)-page evidence packet. The packet included the following documents: the two letters from Molina, dated August 19, 2020; Second Level Review Progress Note, dated April 28, 2020; Notice of Adverse Benefit Determination, dated April 28, 2020; LTC Supplemental Assessment, dated April 14, 2020; Plan of Care, with an effective dated of July 24,

2020; Florida Department of Elder Affairs, 701B Comprehensive Assessment (“701B Assessment”); Florida Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”); Policy and Procedure No. MLTSS-010, approved April 15, 2020; Service Request/Authorization Form, dated January 8, 2020; Corrected Letter from Molina, dated May 29, 2020; and Notice of Plan Appeal Resolution, dated June 18, 2020. Absent an objection from Petitioner, the undersigned admitted Respondent’s evidence packet into evidence as Respondent’s Composite Exhibit 1.

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of Molina’s LTC plan. *See* Respondent’s Composite Exhibit 1 at page 25. Molina is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a 24-year-old female who resides with her mother and sister and daughter. *Id.* at 45 and 54. Petitioner suffers from cerebral palsy, partial paralysis, epilepsy, and severe mental retardation. *Id.* at 30, 46, and 50. She is incontinent of bowel and bladder. *Id.* at 30 and 50. Petitioner uses a Gastrostomy Tube (“G-tube”) for feeding and medications. *Id.* at 3, 30. Petitioner needs supervision while her caregiver transports her sister to tutoring three times per week. *Id.* at 30.

3. Regarding Petitioner’s Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 48.

4. Regarding Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone,

managing money, preparing meals, shopping, managing medication, and using transportation.

*Id.* at 49.

5. Petitioner is currently authorized to receive the following home and community-based services: thirty five (35) hours per week of personal care services, five (5) hours per week of homemaker services, and medical equipment and supplies. *Id.* at 40.

6. On April 28, 2020, Respondent issued an NABD reducing homemaker services from thirty-five (35) hours per week to five (5) hours per week. The NABD explains 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.

...

#### **Other authority**

The 35 hours per week of home making has been reduced to 5 hours per week by the Medical Director because service is not medically necessary. You are already receiving other services that should meet your needs

No recent emergency room visits or hospital stay. You will continue to receive 40 hours of assistance which should meet 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.

The facts that we used to make our decision are: Medical Necessity

*Id.* at 6.

7. On May 29, 2020, Petitioner requested an appeal of Respondent's reduction of homemaker services. *Id.* at 95. On June 18, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 103 – 104. The NPAR stated as follows:

The reason for our decision was based on the Molina Healthcare of Florida Long Term Care (LTC) Policy, which indicates that our "Functional Level and Service Review Tool" is used in combination with an assessment (evaluation) to determine your needs. Evaluations are done during a member's initial assessment, annual re-assessment, and/or when there is a significant change in the members care. A significant change may include, but is not limited to, changes in the member's condition or caregiver. Based on our records, it does not indicate a change in the Yesenia's care. For this reason, the request for the additional 30 hours of Homemaker Services is denied.

Although we are denying the additional 30 hours of Homemaker Services, Yesenia will still receive 5 hours of Homemaker and 35 hours of Personal Care Services.

*Id.* at 103.

8. On August 7, 2020, Petitioner requested a Fair Hearing due to the reduction of homemaker services. On September 16, 2020, the undersigned rescheduled the Fair Hearing at Petitioner's request for October 5, 2020, at [REDACTED], and all parties were duly notified.

9. Ms. Bellina testified that the Petitioner is currently approved for thirty-five (35) hours per week of personal care services, five (5) hours per week of homemaker services, and medical equipment and supplies. Ms. Bellina argued that Petitioner's homemaker services were reduced based on the documentation of her functional needs and the resources she has at home. Ms. Bellina asserted that Petitioner's case manager, and the Molina clinical team, determined that

forty (40) hours per week of combined services are sufficient to meet her needs. She further asserted that the documentation did not support the need for the previously-approved thirty-five (35) hours per week of homemaker services.

10. Ms. Bellina testified that an assessment documenting Petitioner's functional needs is found on pages 17 – 34 of Respondent's Composite Exhibit 1. She asserted that Petitioner is totally dependent with ADLs and IADLs, and that pages 20 – 25 show how Molina calculated the number of minutes required for each ADL and IADL. Referring to the summary on page 25, Ms. Bellina argued that Petitioner needs forty (40) hours per week of combined services. Ms. Bellina further asserted that Petitioner does not need thirty-five (35) hours of homemaker services, because [REDACTED] is available every day to care for Petitioner and is "present around the clock." *Id.* at 15 - 16. Ms. Bellina noted that [REDACTED] is one of two approved Direct Services Workers under the Participant Directed Option ("PDO") program. She argued that [REDACTED] can utilize the other Direct Service Worker to supervise Petitioner when she needs to leave the house.

11. Referring to Respondent's Composite Exhibit 1 at pages 40 - 41, Ms. Matos testified that Petitioner receives forty (40) hours of combined services weekly that can be allocated to meet Petitioner's needs. She argued that, if [REDACTED] needs to leave the house, she can utilize another caregiver to supervise Petitioner at home during that time.

12. [REDACTED] testified that Petitioner has significant neurological conditions and needs permanent care. She suffers from anxiety, and harms herself when in an unfamiliar setting. [REDACTED] testified that Petitioner gets very irritated when she leaves home. [REDACTED] argued that she is a single mother who needs to be able to take her other child to school and tutoring, run errands, and she has no one to supervise Petitioner when she leaves home.

## CONCLUSIONS OF LAW

13. 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).

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

15. 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.

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

17. 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) ("LTC Policy"). The Agency's LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The 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.

...

**1.3.16 Natural Supports** Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

## **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.

...

**4.2.1.1 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.

...

**4.2.2.6 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.

LTC Policy, pages 1-8.

18. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medically necessary or 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.

19. The Molina MLTSS Functional Level and Services Review Policy provides, in pertinent part, as follows:

## II. POLICY

The purpose of this policy is to ensure functional needs are assessed and supporting services decisions made by qualified staff in accordance with Molina's policies and protocols as well as government regulations, policies and contracts.

## III. PROCEDURE

### 1. FUNCTIONAL LEVEL DETERMINATION

A. The Service Coordinator will complete a holistic face to face assessment for individuals that may have functional needs upon initial enrollment and scheduled reassessment, when requested by an enrollee or their authorized designee, or upon an enrollee's significant change in condition using Molina's assessment tools within timeframes governed by the programs policies and procedures.

B. The Service Coordinator will determine an individual's ability to self-perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) during a face to face visit using Molina's Functional Level and Service Review tool. The result is described as the individual's functional level.

C. Using multiple sources such as the individual, caregiver, natural support and observations, the individual's functional level for each ADL and IADL will be documented using the scale below. If a different functional assessment tool or scale is mandated, a crosswalk will map the following criteria to the state mandated tools.

Episodes over a typical 7-day period are considered. An episode is defined as each time the ADL/IADL occurred.

If all episodes are performed at the same level during that time period, score all episodes of that ADL/IADL at level.

To receive a score of 0 (Independent), 6 (Total dependence), and 8 (Activity did not occur) all the episodes of the ADL/IADL would have to be at the same level.

If only one episode occurs during the 3-day period, the functional level would be based on that one episode.

If any episodes are performed at a level 6 (Total dependence), and others are performed at a less dependent level, score ADL/IADL as a 5 (Maximal assistance).

Otherwise, focus on the three most dependent episodes (or all episodes if performed fewer than 3 times). If most dependent episode is 1 (Independent, setup help only), score the need as 1. If not, score the ADL/IADL as least dependent of those episodes in range 2 (Supervision) through 5 (Maximal assistance).

ADL/IADL Functional level is independent of the availability or type of support that provides care.

Respondent's Composite Exhibit 1 at pages 86 – 87.

20. In the instant case, Respondent reduced homemaker services from thirty-five (35) hours per week to five (5) hours per week. See supra ¶ 5 - 7. As established on the record by the evidence and testimony, Respondent reduced homemaker services because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. See supra ¶ 7 and 9.

21. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the SMMC LTC Policy; do not duplicate another service; and meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 17. 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* ¶ 17.

22. The evidence presented in this case reflects that Respondent’s reduction of homemaker services from thirty-five (35) hours per week to five (5) hours per week is warranted under the circumstances of this case. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *See supra* ¶ 3. Regarding IADLs, Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication, and using transportation. *See supra* ¶ 4. Petitioner resides in the home with her mother and sister. *See supra* ¶ 2. Petitioner’s mother is her primary caregiver, and she does not work outside the home. *See supra* ¶ 2. ██████ argued that Petitioner does not like to leave the house, and she needs supervision three times per week while her sister attends tutoring. *See supra* ¶ 12. As Ms. Bellina and Ms. Matos testified, ██████ can utilize another, approved Direct Service Worker to supervise Petitioner at home during that time. *See supra* ¶ 10 and 11. Based upon the evidence presented by both parties, Respondent established that the reduction of homemaker services from thirty-five (35) hours per week to five (5) hours per week is warranted in this case.

23. Additionally, section 1.3.14 of the LTC Policy requires that “LTC supportive 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 ¶ 17. Petitioner is currently authorized to receive the following home and community-based supportive services thirty-five (35) hours per week of personal care services, five (5) hours per week of homemaker services, and medical equipment and supplies. See supra ¶ 5 - 7. As Ms. Matos testified, Petitioner can adjust times the services are provided to meet her needs. See supra ¶ 11. Considering the LTC Policy’s definitions for homemaker services and personal care services, *supra* ¶ 17, Respondent demonstrated that Petitioner’s aforementioned needs, *supra* ¶ 2 – 4, 6, 7, and 12, are sufficiently met by her currently authorized services. Further, given that Respondent established that the requested homemaker services are not warranted in this matter, *supra* ¶ 22, the previously authorized amount of homemaker services are “in excess of [Petitioner’s] needs.” See supra ¶ 7 and 10.

24. Appurtenant to this matter, section 1.3.16 of the LTC Policy provides that natural supports are “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” See supra ¶ 17. The record reflects that Petitioner resides in the home with her mother and sister. See supra ¶ 2. Her mother is her primary caregiver and she does not work outside the home. See supra ¶ 2. Therefore, Petitioner has natural supports available to assist with her care and needs.

25. In light of the both parties’ testimony, Respondent’s Composite Exhibit 1, LTC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent demonstrated that Petitioner’s previously authorized amount of homemaker services is not medically necessary.

26. Accordingly, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent's reduction of homemaker services from thirty-five (35) hours per week to five (5) hours per week was correct.

**DECISION**

Respondent's reduction of homemaker services from thirty-five (35) hours per week to five (5) hours per week is **AFFIRMED**.

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

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



Laura Gallagher  
20-FH [REDACTED]  
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**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
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**2727 Mahan Drive, Mail Stop # 11**  
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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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