STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



[redacted]

APPEAL NO. 15F-02012

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on March 25, 2014 at 11:42 a.m.

## APPEARANCES

For the Petitioner: [redacted] Daughter

For the Respondent: Dianna Chirino, Senior Human Services Program Administrator, Agency for Health Care Administration

## ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through the Petitioner's service provider United Healthcare (UHC), to deny his request to continue his Adult Day Care services five days a week.

## PRELIMINARY STATEMENT

Appearing as witnesses for the Agency from United Healthcare were Christian Laos, Senior Compliance Analyst and Dr. Marc Kaprow, Long-Term Care Medical Director.

Respondent entered two documents into the record, which were marked as Respondent Exhibit 1 and Respondent Composite Exhibit 2. The Petitioner submitted no documents into the record.

Petitioner was present and was represented by his daughter, [redacted] The Petitioner's Son-In-Law, [redacted] also appeared as a witness. Kathy Sarmiento, liaison for SHINE (Service Health Insurance Needs of the Elderly) of the Alliance on Aging, also appeared on behalf of the Petitioner.

At the Respondent's request, administrative notice was taken of 42 C.F.R. § 441.745 (a)(ii)(A); Florida Administrative Rule 59G-1.101(166); Model Long-Term Care contract, Attachment II, Section 5-Covered Services, 1-General Provisions, paragraph b; and Model Contract, Attachment II, Exhibit II-B, pages 8-14.

The Petitioner is currently receiving, per week, five (5) hours of Companion services; 17 hours of Personal Care services; and 32.5 hours of Adult Day Care. The Plan's denial of the Adult Day Care would be accompanied by an increase in the Personal Care services to 20 hours per week and the addition of 10 hours of Homemaker services. During the proceedings, the Respondent's witness indicated that if the denial of Adult Day Care services were upheld an additional seven (7) hours a week of Companion services would be approved. This change would result in a total of 12 hours of Companion services per week. A decision on the denial of Adult Day Care

services will result in either the current plan of services remaining in effect or the proposed plan of services going into effect. The resulting impact on the home health services to be delivered carried no weight in the decision rendered, but was clarified for the benefit of the Petitioner. The decision is solely based on the request for continuing Adult Day Care services.

## FINDINGS OF FACTS

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. The Petitioner is an 88 year-old Medicaid recipient enrolled with United Healthcare as of October 1, 2014, a Florida Long-Term Care provider.

2. The Petitioner has been determined eligible for nursing home placement but has elected to live in his home with his daughter and son-in-law and receive support services to remain in the community.

3. The Petitioner currently attends an adult day care center five days a week, six and a half hours a day. He enjoys playing bingo, dominoes and chatting with other attendees during meals. He has been going to an adult day center since October 2014.

4. The Petitioner submitted a prior authorization on December 12, 2014 to continue receiving the adult day care services five days a week.

5. On December 18, 2014 the Respondent sent the Petitioner a denial notice for the requested adult day care service providing the following pertinent explanation:

> Adult day health care is for helping you with daily activities. Adult day care is also for being social. Being alone in your home is not a reason for adult day health care. For adult day care you must be able to help in your own care. You require extensive care for most of your daily activities. Based on our evaluation you will not benefit from adult day care.

6. The Petitioner timely filed his appeal on February 20, 2015.

7. The Petitioner suffers from advanced senile dementia and needs almost total assistance with all his activities of daily living. He is able to ambulate with the use of a cane, but he needs someone to assist him while walking to prevent falls.

8. The Respondent asserts the Petitioner's severe dementia and dependence on others supports the need for one-on-one services in the home. Additionally, Respondent asserts the adult day center environment does not provide sufficient supervision/oversight to meet the Petitioner's need and, as a result, puts him at risk.

9. The Petitioner's daughter asserts the Petitioner has improved since he has been going to the adult day center. He is less depressed, eager to go to the center in the mornings and enjoys playing games and interacting with the other attendees.

10. The Respondent's physician witness from United Healthcare made the initial denial determination for the adult day care. A second physician with United Healthcare subsequently reviewed and upheld the original denial.

## CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Fla. Stat.

12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent. Per the rule, the standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.

14. Federal Code of Regulations § 441.745 State plan HCBS administration: State responsibilities and quality improvement states in part

> (a) State plan HCBS administration—(1) State responsibilities. The State must carry out the following responsibilities in administration of its State plan HCBS:
>
> (i) Number served. The State will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in State plan HCBS in the previous year.
>
> (ii) Access to services. The State must grant access to all State plan HCBS assessed to be needed in accordance with a service plan consistent with §441.725, to individuals who have been determined to be eligible for the State plan HCBS benefit, subject to the following requirements:
>
> (A) A State must determine that provided services meet medical necessity criteria

15. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Adult day care services is one of the mandatory services that must be provided by the plan.

16. Florida Statutes 409.912 also provides that the Agency may mandate prior authorization for Medicaid services.

17. Florida Statutes 429.901 Definitions, provides in relevant part:

> (1) "Adult day care center" or "center" means any building, buildings, or part of a building, whether operated for profit or not, in which is provided through its ownership or management, for a part of a day, basic services

to three or more persons who are 18 years of age or older, who are not related to the owner or operator by blood or marriage, and who require such services.
(3) "Basic services" include, but are not limited to, providing a protective setting that is as non-institutional as possible; therapeutic programs of social and health activities and services; leisure activities; self-care training; rest; nutritional services; and respite care.

18. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

19. Fla. Admin. Code R. 59G-1.010 (166) also provides...

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. 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
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "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.

(c) 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. Fla. Admin. Code R. 58A-6.009 Basic Services provides the following:

(1) (b) A variety of therapeutic, social and health activities and services which help to restore, remediate, or maintain optimal functioning of the participants and to increase interaction with others. Examples of such programs include exercise, health screening, health education, interpersonal communication, and behavior modification;

21. AHCA's Managed Care Model Contract, Section V. Covered Services provides in relevant part:

A. Required Benefits

1. General Provisions

a. The Managed Care Plan shall ensure the provision of services in sufficient amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract.

b. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition. The Managed Care Plan may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.

22. AHCA's ATTACHMENT II, EXHIBIT II-B – Effective Date: January 15, 2015, LONG-TERM CARE (LTC) MANAGED CARE PROGRAM, SECTION V. COVERED SERVICES provides in relevant part:

A. Required Benefits

1. Specific LTC Services to be Provided

a. The Managed Care Plan shall provide the services listed below in accordance with the Florida Medicaid State Plan, the Florida Medicaid

> Coverage and Limitations Handbooks, the Florida Medicaid fee schedules, and the provisions herein, unless otherwise specified elsewhere in this Contract. The Managed Care Plan shall comply with all state and federal laws pertaining to the provision of such services. The following provisions highlight key requirements for certain covered services, including requirements specific to the LTC program.
>
> (1) Adult Companion Care — Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
>
> (2) Adult Day Health Care — Services provided pursuant to Chapter 429, Part III, F.S. Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and **supervision of self-care services directed toward activities of daily living and personal hygiene**, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the Managed Care Plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The Managed Care Plan may contract with the adult day health care provider for the delivery of these services or the Managed Care Plan may contract with other providers qualified to deliver these services pursuant to the terms of this Contract [emphasis added].

23. The Respondent asserts that the Petitioner's need for help with most of his activities of daily living (ADLs) as well as his need for one-on-one supervision presents a risk to his health and well being if he continues to attend the Adult Day Care(ADC). The Petitioner would benefit most from the one-on-one services he will receive in his

home. The Respondent explained that the companion services would be increased and can be used as the Petitioner and caregivers choose to help with his socialization needs.

24. The Petitioner's daughter argued that the services in the home cannot replace the services provided by the Adult Day Care. The Petitioner looks forward to going to the ADC and enjoys playing bingo, dominoes and chatting with the other attendees.

25. The decision to replace the Adult Day Care services with one-on-one home health services in the home is a clinical decision within the above cited authorities. While socialization is one of the primary services provided by the Adult Day Care services to the Petitioner, Companion services also provide for the Petitioner's socialization needs. The Respondent's decision for denying the Adult Day Care services is based on the assessed risk to the Petitioner at the ADC due to his dementia as well as his significant need for assistance with his activities of daily living (ADLs). The denial of ADC services has been made by two of the physicians with the Petitioner's managed care plan and is based on the lack of medical necessity for the services. The Respondent's evidence and testimony document that the Petitioner's health and well being can best be met with one-on-one services in the home.

26. The Petitioner failed to meet his burden of proof that the Adult Day Care services are medically necessary.

## DECISION

Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Agency for Health Care Administration, through the long-term care

provider United Health Care, acted correctly when it denied Petitioner's request for five days of Adult Day Care per week. Therefore, the Petitioner's appeal is hereby denied.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 11th day of May, 2015,

in Tallahassee, Florida.

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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager