



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

FILED

Jan 20, 2021, 11:17 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Medicaid Fair Hearing in the above styled case on November 23, 2020, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Kizzy Alleyne

Senior Manager of Compliance

Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's homemaker services was correct.

PRELIMINARY STATEMENT

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

Kizzy Alleyne, Senior Manager for Compliance for Sunshine State Health Plan, Inc. (“Sunshine”), represented Respondent at the hearing. Dr. Bonnie Korreiff-Wolf (“Dr. Koreff-Wolf”), Medical Officer for Sunshine, provided testimony for Respondent. The following individuals also provided testimony for on Respondent: Louise Jeanty, Supervisor of Quality Improvement, Leanne Murphy, Long Term Care Coordinator for Sunshine, and Talia Aguiar, Long Term Care Case Manager for Sunshine, appeared at the hearing but did not testify.

Doris Rivera, Medical Healthcare Program Analyst for the Agency for Health Care Administration (“Agency”) appeared for observational purposes.

Petitioner did not submit any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-one (121)-page evidence packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; a Medicaid Fair Hearing Summary, dated November 2, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated September 22, 2020; Sunshine’s care plans, signed August 24, 2020, and October 30, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B Assessment”), dated August 24, 2020; 701B Assessment, dated October 30, 2020; fax cover paged, dated October 2, 2020; letter for medical necessity from [REDACTED] (“[REDACTED]”), dated October 1, 2020; letter from Petitioner, faxed on September 29, 2020; Request for an Appeal of Grievance Form; Expedited Appeal Request Decision, dated October 2, 2020; Standard Appeal Acknowledgement, dated October 2, 2020; Notice of Plan Appeal Resolution, dated October 13, 2020; the Sunshine Health Policy and Procedure LT.UM.09; and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010.

Absent an objection from Petitioner, the undersigned admitted Respondent's 121-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 at page 13. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a [REDACTED] year old female who resides in a private residence with her daughter and son-in-law, and [REDACTED] does not work outside the home. *Id.* at 14, 50 and 63. Petitioner suffers from high blood pressure, diabetes, high cholesterol, and neuropathy. *Id.* at 55 - 56. Petitioner is sometimes forgetful but "does not have a mental health diagnosis indicating mental health concerns." *Id.* at 51 and 58. [REDACTED] is willing to continue to provide natural support to Petitioner. *Id.* at 64.

3. Regarding Petitioner's Activities of Daily Living ("ADLs"), Petitioner needs total assistance (cannot do at all) with bathing and dressing. *Id.* at 53. Petitioner needs assistance (but not total help) with using the bathroom. *Id.* Petitioner needs supervision or prompt with transferring. *Id.* Petitioner uses an assistive device with walking/mobility. *Id.* Petitioner always has assistance with ADLs when needed. *Id.*

4. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), Petitioner needs total assistance (cannot do at all) with heavy chores and light housekeeping. *Id.* at 54. Petitioner needs assistance (but not total help) with managing money, shopping, managing medication, and using transportation. *Id.* Petitioner needs no assistance with using the telephone. *Id.* Petitioner always has assistance with IADLs when needed. *Id.*

5. In addition to the homemaker services at issue in this case, Petitioner is currently authorized to receive twenty (20) hours per week of personal care services. *Id.* at 29.

6. The letter from Petitioner's physician, [REDACTED], dated October 1, 2020, states as follows:

PLEASE BE ADVISED THAT MY PATIENT, [PETITIONER], IS IN DECLINING HEALTH. SHE IS WHEELCHAIR BOUND, NEEDS HELP WITH ALL HER ADL'S, HAS DEMENTIA AND DUE TO HER AGE OF [REDACTED] YEARS, SHE CAN NOT BE LEFT ALONE.

SHE NEEDS A MINIMUM OF 10 HOURS A DAY OF HOME MAKER SERVICES WHICH I FEEL IS MEDICALLY NECESSARY. THE DAUGHTER, [REDACTED], IS HER CAREGIVER FOR WHOM SHE IS TOTALLY DEPENDENT ON.

Id. at 68 [caps in original].

7. On September 22, 2020, Respondent issued an NABD terminating Petitioner's homemaker services. *Id.* at 4– 8. The NABD states 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 wither of the reason(s) checked below: *(See Rule)*

Meet all of the following criteria for all extended state plan services use 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: Sunshine Health has looked at the member's present care needs and provided home services. The member's present care plan includes 20 hours per week of Personal Care Services and 10 hours per week of Homemaker Services. Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will terminate the 10 hours per week of Homemaker Services. The updated care plan approved by Sunshine Health will include 20 hours per week of Personal Care Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 4 – 5.

8. On September 29, 2020, Petitioner requested an appeal of Respondent's termination of homemaker services. *Id.* at 77. On October 13, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 83 - 85. The NPAR stated as follows:

On September 29, 2020 we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated September 22, 2020, Notice of Adverse Benefit Determination Number [REDACTED], TERMINATING the 10 hours per week of homemaker services provided to [Petitioner].

On October 12, 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 10 hours per week of homemaker services, effective October 12, 2020.

The reason for our decision was the reconsideration of the termination of 10 hours of Homemaking Services (the person who helps you around the house) is denied. Original termination is upheld (stands). After review of member's current situation, the member's current services are adequate (enough) to meet the member's care needs[.]LT.UM.09, LTC (Long Term Care) Ancillary Service Criteria was referenced in making this decision.

This decision was made by a Medical Director who is Board Certified in Cardiovascular Disease.

Id. at 83.

9. Sunshine's Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria provides the following regarding the approval of homemaker services:

6. Homemaker Services

Homemaker provides assistance with essential shopping, light housework, laundry, and meal preparation. These services are provided to members who exhibit a functional deficit that impairs their ability to complete these tasks and lack an available support system. Services are provided to support member's health, safety, and ensure basic standards are met. Services are provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities.

Approval Criteria

Homemaker Service reviews include four (4) criteria:

- a) Instrumental Activity of Daily Living (IADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

Id. at 76.

10. On October 23, 2020, Petitioner requested a Fair Hearing due to the termination of homemaker services. The undersigned scheduled the Fair Hearing for November 23, 2020, at [REDACTED], and all parties were duly notified.

11. Dr. Koreff-Wolf is Sunshine's Medical Director. She argued that ten (10) hours weekly of homemaker services are in excess of Petitioner's needs. She asserted that, based on the information Sunshine had at the time they made the decision, the termination of homemaker services is correct. Dr. Koreff-Wolf testified that in making the decision, Sunshine looked at the information that came from the case manager, Petitioner's 701B Assessment, and the Petitioner's circumstances of living with her daughter, who and does not work outside the home, and her son-in-law. She argued that the 701B Assessment states that Petitioner does not need total assistance with all her ADLs and IADLs, and she can use some personal care hours for homemaker types of services.

12. ██████ asserted that Petitioner requires round the clock care and she is unable to provide it. She stated that Petitioner is unable to walk and is totally dependent for assistance with transfers. ██████ asserted that she cleans the commode 4 – 5 times per day for Petitioner and that Petitioner soils her bed several times per day if left unattended. ██████ changes Petitioner’s linens and does Petitioner’s laundry separate from her usual laundry day for the household. ██████ argued that Petitioner is in decline, in the early stages of dementia, and requires regular attention.

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 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 terminating existing services, 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 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.

...

4.2.1.9 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 at 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 “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. In the instant case, Respondent terminated Petitioner’s homemaker services. *See supra* ¶ 7 and 8. As established on the record by the evidence and testimony, Respondent terminated the services because the documentation submitted in support of Petitioner’s request failed to establish that the services were medically necessary. *See supra* ¶ 7, 8, 11.

20. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the LTC Policy; do not duplicate another service; and meet the criteria as specified in the LTC Policy. *See supra* ¶ 17. Section 4.2.1.9 of the 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*” [emphasis added]. See supra ¶ 17.

21. The evidence presented in this case reflects that Respondent’s termination of homemaker services is warranted under the circumstances of this case. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with bathing and dressing. See supra ¶ 3. Petitioner needs assistance (but not total help) with using the bathroom. See supra ¶ 3. Petitioner needs supervision or prompt with transferring. See supra ¶ 3. Petitioner uses an assistive device with walking/mobility. See supra ¶ 3. Petitioner always has assistance with ADLs when needed. See supra ¶ 3. Regarding IADLs, Petitioner needs total assistance (cannot do at all) with heavy chores and light housekeeping. See supra ¶ 4. Petitioner needs assistance (but not total help) with managing money, shopping, managing medication, and using transportation. See supra ¶ 4. Petitioner needs no assistance with using the telephone. *Id.* Petitioner always has assistance with IADLs when needed. See supra ¶ 4. Petitioner resides in the home with ██████████, who does not work outside the home, and her son-in law. See supra ¶ 2, 7, 8, and 11. ██████████ is Petitioner’s primary caregiver and is willing to provide care for Petitioner. See supra ¶ 2.

22. 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 twenty (20) hours per week of personal care services. See supra ¶ 5. Considering the LTC Policy’s definitions for homemaker services and personal care services, *supra* ¶ 17, Respondent demonstrated that Petitioner’s aforementioned homemaker

service needs, *supra* ¶ 2 - 4, 7, 8 and 10 - 11, are sufficiently met by her currently authorized services. Further, given that Respondent established that the requested level of homemaker services are not warranted in this matter, the previously authorized amount of homemaker services are in excess of Petitioner's needs. *See supra* ¶ 7, 8 and 11.

23. 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 [REDACTED] and her son-in-law. *See supra* ¶ 2. [REDACTED] is Petitioner's primary caregiver and she does not work outside the home. Further, she is willing to continue to provide natural support. *See supra* ¶ 2. Therefore, Petitioner has natural supports available to assist with her care and needs. Petitioner's physician submitted a letter recommending a minimum of 10 hours per day of homemaker services. *See supra* ¶ 6. As previously stated, Petitioner is approved for 20 hours per week of personal care services and has natural supports available. Pursuant to the Definitions Policy, “[t]he 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.” *See supra* ¶ 18.

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

25. Accordingly, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent's termination of ten (10) hours per week of homemaker services was correct.


DECISION

Respondent's termination of ten (10) hours per week of homemaker services is **AFFIRMED**.

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

DONE AND ORDERED this 20th day of January, 2021, in Tallahassee, Leon County, Florida.



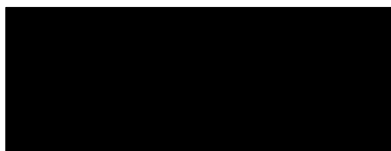
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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.

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