



**FILED**

Jan 15, 2021, 9:30 am

OFFICE OF FAIR HEARINGS

**STATE OF FLORIDA  
AGENCY FOR HEALTH CARE ADMINISTRATION  
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 Hearing Officer convened a telephonic Medicaid Fair Hearing in the above-styled case on December 30, 2020, at [REDACTED]

[REDACTED]

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Louise Jeanty  
Quality Improvement Supervisor  
Sunshine State Health Plan, Inc.

**STATEMENT OF ISSUE**

By stipulation of the parties, the issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional 119 hours per week of personal care services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and son, appeared for the hearing and provided testimony on his own behalf.

Louise Jeanty, Quality Improvement Supervisor for Sunshine State Health Plan, Inc. (“Sunshine”), appeared as a representative for Respondent. Dr. John Carter (“Dr. Carter”), Long Term Care Medical Director for Sunshine, appeared as a witness for Respondent. Susan Walker, Long Term Care Case Manager for Sunshine, appeared on behalf of Respondent but did not testify.

Chrissie Simmons, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Petitioner did not submit an evidence package prior to or during the Fair Hearing. Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twelve (112)-page hearing packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; Medicaid Fair Hearing Summary, dated November 6, 2020; Notice of Adverse Benefit Determination (“NABD”), dated August 18, 2020; Long Term Care Person-Centered Care Plan, signed July 27, 2020; Long Term Care Person-Centered Care Plan, signed October 9, 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment (“July 701B Assessment”), dated July 28, 2020; 701B Assessment, dated October 9, 2020 (“October 701B Assessment”); Standard Appeal Acknowledgement, dated September 4, 2020; Notice of Plan Appeal Resolution (“NPAR”), dated September 27, 2020; Sunshine Health Policy and Procedure, LTC (Long Term Care) Ancillary Service Criteria, LT.UM.09; and Florida Administrative Code Rule (“Fla. Admin.

Code R.”) 59G-1.010. Absent an objection, the undersigned admitted Respondent’s one hundred and twelve (112)-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of Sunshine’s Florida Medicaid Managed Medical Assistance plan and Long Term Care plan. *See* Respondent’s Composite Exhibit 1 at pages 2 and 13. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a ■■■■■ year-old male who lives alone in a private residence. *Id.* at 50. Petitioner is legally blind, wears hearing aids, and is diagnosed with dementia, gastroesophageal reflux disease (“GERD”), osteoarthritis, diabetes, incontinence of bowel and bladder, and ulcers. *Id.* at 51 and 55 - 56. Petitioner’s October 701B Assessment states, “10/2020 member has declined significantly – weaker, not walking as far, sleeping more, eating less, frequent falling.” *Id.* at 51. Further, the 701B indicated that Petitioner does not need supervision, *Id.* at 58, and that Petitioner’s son wired Petitioner’s home with video cameras and sensors. *Id.* at 50.

3. Regarding Activities of Daily Living (“ADLs”), Petitioner needs total assistance (but not total help) with bathing, dressing, using the bathroom, and transferring. *Id.* at 53. Petitioner needs no assistance with eating. *Id.* Regarding the amount of assistance Petitioner has with ADLs, Petitioner has assistance most of the time with using the bathroom. *Id.* Petitioner always has assistance with bathing, dressing, and walking/mobility. *Id.* Petitioner’s October 701B Assessment states, “Member is wetting himself more – he is wetting floor and furniture and his clothes more frequently.” *Id.*

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 54. Petitioner always has assistance with his aforementioned IADLs. *Id.* Petitioner’s “HCA keeps the cookies and milk for [Petitioner] to access nightly around 1 – 3 in the morning.” *Id.*

5. On August 18, 2020, Respondent issued an NABD denying Petitioner’s request for an additional personal care services, explaining that the requested services are not medically necessary. *Id.* at 4. The NABD stated:

Sunshine Health has reviewed your request for an extra 124 hours per week of personal care (the person who helps bathe and dress you), which were received on 08/11/2020. After our review, this service has been: DENIED as of 08/18/2020.

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 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 an extra 124 hours/week of Personal Care Services is denied. 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:

- 14 hours/week of Personal Care Services
- 6 hours /week of Homemaker Services
- 10 hours/week of Companion Care Services
- 7 meals/week of Home Delivered Meals
- 

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

*Id.* at 4 – 6.

6. Petitioner requested a plan appeal. *Id.* at 67 – 69. On September 27, 2020, Respondent sent Petitioner an NPAR approving 19 additional hours of personal care services. *Id.* The NPAR stated:

On September 24, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby partially approves your plan appeal. As a result, [Petitioner] will receive an extra 19 hours per week of Personal Care Services (the person who bathe[s] and dress[es] you), effective Septem[ber] 24, 2020.

The reason for our decision was:

The appeal to overturn the denial of an extra 124 hours per week of Personal Care Services (the person who bathe and dress you) is partially approved. Based on the assessment of your care needs and household and caregiver status, Sunshine Health will approve an extra 19 hours per week of Personal Care Services (the person who bathe and dress you), and will deny the remaining requested 105 hours per week of Personal Care Services (the person who bathe and dress you).

The updated care plan approved by Sunshine Health will include:

- 33 hours per week of Personal Care Services (the person who bathe and dress you)
- 6 hours per week of Homemaker Services (the person who cleans for you)
- 10 hours per week of Companion Care Services (the person who helps and watches over you)

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

*Id.* at 74.

7. Petitioner is currently authorized to receive 33 hours per week of personal care services, 6 hours per week of homemaker services, and 10 hours per week of companion care services. *Id.* at 3 and 25. By stipulation of the parties, Sunshine denied the additional 119 hours per week of personal care services, which are at issue in this case.

8. On October 22, 2020, Petitioner requested a Fair Hearing due to the denial of additional personal care services. On November 6, 2020, the undersigned scheduled the Fair Hearing for November 24, 2020. At the request of Petitioner's Authorized Representative, the undersigned rescheduled the Fair Hearing for December 30, 2020, at [REDACTED], and all parties were duly notified.

9. At the Fair Hearing, [REDACTED] testified that he is a registered nurse. [REDACTED] explained that he began living with Petitioner after Petitioner's recent hospitalization for pneumonia. [REDACTED] asserted that his employer gave him temporary flexibility, which has enabled him to live with Petitioner on a short-term basis. However, he will not be able to live with Petitioner permanently. [REDACTED] stated that his brother occasionally stays with Petitioner at night, but he is unable to do so on a regular basis because he travels out of state on business. [REDACTED] asserted that Petitioner needs additional personal care services because he lives alone, and his health is in decline. [REDACTED] asserted that in addition to dementia, Petitioner is legal blind, hearing impaired, completely incontinent, unable to ambulate without

assistance, and a cancer patient. [REDACTED] added that Petitioner must be prompted to eat, uses oxygen, and has other co-morbidities.

10. Dr. Carter stated that based on the documentation provided and [REDACTED] testimony, he is comfortable issuing a medical director override to add an additional 63 hours per week of personal care services. Dr. Carter clarified that, with the additional services, Petitioner would receive a total of 112 hours per week of paid services or approximately 16 hours per day for 7 days per week. [REDACTED] stated that the increased hours are insufficient due to his work schedule as a registered nurse and the fact that he is only able to live with Petitioner on a temporary basis.

#### **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 section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 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 additional services, 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 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 Home and Community-Based Supportive Services**

The LTC program benefit includes coverage of the following home and community-based supportive services:

...

#### **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.

...

#### **4.2.2 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:

...

#### **4.2.2.5 Medical Equipment and Supplies**

In accordance with Rule 59G-4.070, F.A.C. This service includes the provision of medical equipment and supplies specified in the plan of care, including: devices, controls, or appliances that enable the enrollee to increase the ability to perform activities of daily living; devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; items necessary for life support or to address an enrollee's physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State Plan that is necessary to address enrollee needs, including consumable medical supplies, such as adult diapers; and repair of such items or replacement parts.

...

#### **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.

16. The Personal Care Services Coverage Policy (November 2016) ("PC Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, states as follows:

#### **1.1 Description**

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to

accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

#### **1.1.2 Statewide Medicaid Managed Care Plans**

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

...

#### **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.

...

#### **1.3.6 Home Health Services**

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

#### **4.2 Specific Criteria**

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

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

PC Policy at pages 3 - 5.

17. 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.

18. In the instant case, Petitioner requested an additional 119 hours of personal care services per week. *See supra* ¶ 7. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, in part, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *Id.* at 5 and 6.

19. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. *See supra* ¶ 15.

20. Section 4.2.2.6 of the LTC Policy indicates that personal care services are "[t]o 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." *See supra* ¶ 15.

21. The evidence presented in this case does not demonstrate that Petitioner is in need of an additional 119 hours per week of personal care services. Specifically, Fla. Admin. Code R. 59G-1.010 requires that a service “[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.” In this case, the Petitioner requires total assistance (cannot do at all) with bathing, dressing, using the bathroom, and transferring, and walking/mobility. *See supra* ¶ 3. Petitioner needs no assistance with eating. *See supra* ¶ 3. Further, Petitioner has assistance most of the time with his ADLs. *See supra* ¶ 3. With regard to IADLs, Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, preparing meals, shopping, managing money, managing medication, and using transportation. *See supra* ¶ 4. Petitioner always has assistance with his IADLs. *See supra* ¶ 4. The record also indicates that Petitioner has a level of natural supports available to assist with his care and needs. [REDACTED] currently lives with Petitioner; however, he indicated that it is on a temporary basis. *See supra* ¶ 9. [REDACTED] further indicated that his brother assists with overnight care on occasion. *See supra* ¶ 9. 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* ¶ 16. In addition, the record indicates that Petitioner’s health is in decline. *See supra* ¶ 2 and 9. Petitioner is a fall risk, growing weaker over time, and was recently hospitalized twice with pneumonia. *See supra* ¶ 2 and 9. Petitioner is wetting himself more. *See supra* ¶ 3.

22. Petitioner’s declining health led Dr. Carter to testify that, based on the evidence and testimony at the hearing, he is comfortable issuing a medical director override to add an additional 63 hours per week of personal care services. *See supra* ¶ 10. Dr. Carter clarified that,

with the override, Petitioner would be approved for a total of 112 hours per week of paid services or approximately 16 hours per day for 7 days per week. See *supra* ¶10. Based on Dr. Carter's testimony, it is clear that some amount of additional personal care services are warranted for Petitioner. Other than ██████████ testimony, Petitioner provided no additional evidence (i.e., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to justify the approval of an additional 119 hours of personal care services weekly or to quantify Petitioner's personal care needs. The October 701B Assessment mentions that Petitioner's "HCA keeps the cookies and milk for [Petitioner] to access nightly around 1 – 3 in the morning." See *supra* ¶4. But, the assessment did not identify an unmet need for assistance with regard to Petitioner's ADLs or IADLs or, specifically, an unmet need for assistance during the night. See *supra* ¶ 3 and 4. Petitioner's currently approved 33 hours is consistent with the description of Petitioner's needs and time needed to complete ADLs contained in Petitioner's 701B Assessment. See *supra* ¶ 3. Petitioner is also receiving 6 hours per week of homemaker services, and 10 hours per week of companion care services. See *supra* ¶ 7.

23. Therefore, considering Petitioner's currently authorized services, along with the LTC Policy definition for personal care services, homemaker services, companion care services and natural supports, Petitioner did not demonstrate that the entire 119 hours of additional personal care services are medically necessary to meet Petitioner's aforementioned needs, *supra* ¶ 2 – 4 and 9. Given that Petitioner failed to establish that the requested amount of additional personal care services are warranted in this matter, *supra* ¶ 22 - 23, the requested personal care services are "in excess of [Petitioner's] needs." See *supra* ¶ 15.

24. In light of the both parties' testimony, Respondent's Composite Exhibit 1, the LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving that the additional 119 hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the requested additional personal care services was incorrect.

**DECISION**

Respondent's denial of an additional 119 hours per week of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

**DONE AND ORDERED** this 15th day of January 2021, 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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**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**



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