



FILED

May 13, 2021, 4:15 pm
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.

_____ /

[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 preliminary hearing in the above-styled case on January 11, 2021, at [REDACTED]

[REDACTED] The undersigned Hearing Officer reconvened a telephonic Fair Hearing in the instant case on April 13, 2021, at [REDACTED].

APPEARANCES

For the Petitioner:

[REDACTED]
Counsel for Petitioner

For the Respondent: Paige S. Comparato
Counsel for Respondent

Craig H. Smith
Counsel for Respondent

STATEMENT OF ISSUE

The first issue is whether Petitioner’s request for a Medicaid Fair Hearing, regarding Respondent’s termination of ten (10) hours per week of Respite Care services, complied with Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(8)(e) regarding the plan appeal process with respect to Notice of Adverse Benefit Determination (“NABD”) (dated August 21, 2020) (Plan ID: ██████████).

The second issue is whether Petitioner’s request for a Medicaid Fair Hearing regarding Respondent’s denial of an additional eighty-four (84) hours per week of Personal Care services complied with Fla. Admin. Code R. 59G-1.100(18)(h).

The third issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional fifty-seven (57) hours per week of Personal Care services was incorrect.

The fourth issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional ten (10) hours per week of Personal Care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the scheduled preliminary hearing and the scheduled Fair Hearing telephonically.

██████████ (“██████████”), Counsel for Petitioner and Petitioner’s Healthcare Surrogate, appeared for the preliminary hearing and appeared for the Fair Hearing on behalf of Petitioner. Petitioner appeared for the Fair Hearing and provided testimony. The following persons appeared for the Fair Hearing as witnesses for the Petitioner: ██████████, Petitioner’s mother; ██████████, Petitioner’s father; and ██████████ (“██████████”), Petitioner’s previous caretaker and a Certified Nursing Assistant (“CNA”).

Paige S. Comparato (“Attorney Comparato”), Associate for Hogan Lovells US LLP, appeared for the preliminary hearing and appeared for the Fair Hearing as Counsel for Respondent. Melissa Layne (“Ms. Layne”), Senior Manager for Member Appeals for Sunshine State Health Plan, Inc. (“Sunshine Health”), appeared for the preliminary Hearing as a representative for Respondent. The following persons appeared for the preliminary hearing and appeared for the Fair Hearing as witnesses for Respondent: Dr. John Carter (“Dr. Carter”), Medical Director for Sunshine Health; Jenni Zwegers (“Ms. Zwegers”), Case Manager Supervisor for Sunshine Health; and Tracey Resch (“Ms. Resch”), Care Coordinator for Sunshine Health. The following persons appeared only for the Fair Hearing as witnesses for Respondent: Christian Pacheco (“Ms. Pacheco”), Senior Director of Quality Improvement for Sunshine Health; and Amanda Fox (“Ms. Fox”), Care Coordinator for Sunshine Health.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the preliminary hearing as an observer. Marielisa Amador, Medical Health Care Program Analyst for the Agency, appeared for the Fair Hearing as an observer.

On November 24, 2020, Petitioner sent to the Office of Fair Hearings (“Office”) and Respondent a sixty-one (61) page evidence packet, which was admitted into evidence as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 includes the following: an email from ██████████, Legal Assistant and Marketing Director for ██████████ (dated November 18, 2020); a cover letter (dated November 18, 2020); a Florida Designation of Health Care Surrogate form (executed on October 6, 2018); a Notice of Appearance (“NOA”) (dated November 18, 2020); a Request for an Appeal of Grievance Form (dated November 15, 2020); a Notice of Appeal or, In The Alternative, Request for Fair Hearing (dated November 18, 2020); a Notice of Adverse Benefit Determination (“NABD”) (dated September 24, 2020) (Plan ID: ██████████); an NABD (Dated September 24, 2020); an NABD (dated March 13, 2019); a Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B Comprehensive Assessment”) excerpts; Notice of Plan Appeal Resolution (“NPAR”) (dated May 16, 2019); a 701B Comprehensive Assessment excerpt; a letter from ██████████ (“████████”) (dated November 16, 2020); Medical records from ██████████ (dates of service: ██████████ 2020, ██████████ 2020, ██████████ 2020); a Request for Fair Hearing (dated November 18, 2020); and a Request for Production of Documents (dated November 18, 2020).

Also, on November 24, 2020, Petitioner sent to the Office and Respondent a forty (40) pages evidence packet, which was admitted into evidence as Petitioner’s Composite Exhibit 2. Petitioner’s Composite Exhibit 2 includes the following: an email from ██████████, Legal Assistant and Marketing Director for ██████████ (dated November 23, 2020); a cover letter (dated November 23, 2020); four copies of an NABD (dated October 2, 2020) (Plan ID: ██████████); and a letter from ██████████ (dated September 17, 2020).

Also, on November 24, 2020, Petitioner sent to the Office and Respondent a sixty-six (66) page evidence packet, which was admitted into evidence as Petitioner's Composite Exhibit 3. Petitioner's Composite Exhibit 3 includes the following: an email from [REDACTED], Legal Assistant and Marketing Director for [REDACTED] (dated November 19, 2020); a cover letter (dated November 19, 2020); a cover letter (dated November 18, 2020); a Florida Designation of Health Care Surrogate form (executed on October 6, 2018); a NOA (dated November 18, 2020); a Request for an Appeal of Grievance Form (dated November 15, 2020); a Notice of Appeal or, In The Alternative, Request for Fair Hearing (dated November 18, 2020); an NABD (dated September 24, 2020) (Plan ID: [REDACTED]); an NABD (dated March 13, 2019) ; an NPAR (dated May 16, 2019); a Florida Department of Elder Affairs 701B Comprehensive Assessment excerpts; a letter from [REDACTED] (dated November 16, 2020); Medical records from [REDACTED] (dates of service: [REDACTED] 2020, [REDACTED] 2020, [REDACTED] 2020); a Request for Fair Hearing (dated November 18, 2020); a Request for Production of Documents (dated November 18, 2020); an email from Respondent (dated November 18, 2020); an email from the Agency (dated November 18, 2020); and a letter from [REDACTED] (dated September 17, 2020).

On December 21, 2020, Respondent sent to the Office and Petitioner a one hundred and twenty-seven (127) page evidence packet, which was admitted into evidence as Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following: a Table of Contents; a Medicaid Fair Hearing Summary (dated December 15, 2020); an NABD (dated September 24, 2020) (Plan ID: [REDACTED]); a Long Term Person-Centered Care Plan ("Plan of Care") (signed on March 11, 2020); a Plan of Care (signed on December 11, 2020); a 701B Comprehensive Assessment (dated August 26, 2020); a 701B Comprehensive Assessment (dated

November 20, 2020); a Standard Appeal Acknowledgement letter (dated November 19, 2020); an Expedited Appeal Request Decision (dated November 19, 2020); an NPAR (dated December 11, 2020); and Sunshine Health's internal policy: LTC (Long Term Care) Ancillary Service Criteria (LT.UM.09); and Fla. Admin. Code R. 59G-1.010.

On December 21, 2020, Respondent also sent to the Office and Petitioner a one hundred and twenty-seven (127) page evidence packet, which was admitted into evidence as Respondent's Composite Exhibit 2. Respondent's Composite Exhibit 2 includes the following: a Table of Contents; a Medicaid Fair Hearing Summary (dated December 15, 2020); a NABD (dated October 2, 2020); a Plan of Care (signed on March 11, 2020); a Plan of Care (signed on December 11, 2020); a 701B Comprehensive Assessment (dated August 26, 2020); a 701B Comprehensive Assessment (dated November 20, 2020); a Standard Appeal Acknowledgement letter (dated November 19, 2020); an Expedited Appeal Request Decision (dated November 19, 2020); a NPAR (dated December 11, 2020); and Sunshine Health's internal policy: LTC (Long Term Care) Ancillary Service Criteria (LT.UM.09); and Fla. Admin. Code R. 59G-1.010.

On December 23, 2020, Petitioner sent to the Office and Respondent a seventy-one (71) page evidence packet, which was admitted into evidence as Petitioner's Composite Exhibit 4. Petitioner's Composite Exhibit 4 includes the following: an email from [REDACTED], Legal Assistant and Marketing Director for [REDACTED] (dated November 18, 2020); an Omnibus Response to the two (2) separate Orders to Show Cause dated December 15, 2020; a fax transmittal sheet (dated December 11, 2020); a NPAR ([REDACTED]) (dated December 11, 2020); a fax transmittal sheet (dated December 11, 2020); a letter from [REDACTED] (dated September 17, 2020); Respondent e-mail correspondence (dated November 30, 2020, November

23, 2020, November 24, 2020); 701B Comprehensive Assessment (dated August 26, 2020); 701B Comprehensive Assessment (dated November 20, 2020); Respondent correspondence (dated November 25, 2020); and a Request for Production of Documents (signed on November 18, 2020).

On January 22, 2021, Petitioner sent to the Office a forty-one (41) page evidence packet, which was admitted into evidence as Petitioner's Composite Exhibit 5. Petitioner's Composite Exhibit 5 includes the following: an email from [REDACTED], Legal Assistant and Marketing Director for [REDACTED] (dated January 22, 2021); Notice of Filing in Response to Respondent, Sunshine Health's Supplemental Evidence submission; a NABD (dated August 21, 2020) (Plan ID: [REDACTED]); an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); Respondent's Member Notes; a letter from [REDACTED] (dated September 17, 2020); a Request for Production of Documents (dated November 18, 2020).

The undersigned Hearing Officer held the record open until January 19, 2021, at 5:00 p.m. EST, for Attorney Comparato to produce documentation regarding telephonic communication between Sunshine Health and Petitioner, and documentation regarding whether the NABD (dated August 21, 2020) (Plan ID: [REDACTED]) was mailed to Petitioner.

The undersigned Hearing Officer held the record open until January 26, 2021, at 5:00 p.m. EST, for [REDACTED] to file a response to Attorney Comparato's production of documents.

On January 28, 2021, Petitioner introduced an evidence packet containing twelve (12) pages, which was admitted into evidence as Petitioner's Composite Exhibit 6. Petitioner's Composite Exhibit 6 includes the following: an email from [REDACTED] (dated January 27, 2021); Petitioner's Notice of Supplemental Filing in Response to Respondent, Sunshine State Health

Plan, Inc.'s Additional Supplemental Evidence submission on January 27, 2021 (dated and signed on January 27, 2021); an email fax transmission confirmation (dated September 17, 2020); a fax cover sheet (September 17, 2020); a letter from [REDACTED] (dated September 17, 2020); and a Sunshine Health letter (Unable to Process Appeal) (dated September 24, 2020).

On February 16, 2021, Petitioner introduced an evidence packet containing sixty-three (63) pages, which was admitted into evidence as Petitioner's Composite Exhibit 7. Petitioner's Composite Exhibit 7 includes the following: Petitioner's Response to the February 5, 2021 Order to Show Cause; Petitioner's Notice of Filing in Response to Respondent, Sunshine State Health Plan, Inc.'s ("SUNSHINE") Supplemental Evidence submission; an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); Sunshine Health internal notes (dated August 21, 2020, through August 27, 2020); a letter from [REDACTED] (dated September 17, 2020); a Request for Production of Documents (dated November 18, 2020); Petitioner's Notice of Supplemental Filing in Response to Respondent, Sunshine Health's Additional Supplemental Evidence submission on January 27, 2021; a fax cover sheet (September 17, 2020); a letter from [REDACTED] (dated September 17, 2020); and a Sunshine Health letter (Unable to Process Appeal) (dated September 24, 2020).

On April 5, 2021, Petitioner introduced an evidence packet containing five hundred and fifty-nine (559) pages, which was admitted into evidence as Petitioner's Composite Exhibit 8. Petitioner's Composite Exhibit 8 includes the following: an email from [REDACTED] (dated April 5, 2021); Petitioner's Exhibit List – Fair Hearing (dated April 2, 2021); a Final Order for 19-FH [REDACTED] and 19-[REDACTED] (issued on September 6, 2019); a fax cover sheet (dated November 7, 2019); Sunshine Health correspondence (dated September 9, 2019); a Home Health Certification and

Plan of Care (dated November 7, 2019); a fax cover sheet (dated November 19, 2019); a fax transmission confirmation email (dated November 8, 2019); a Home Health Certification and Plan of Care (dated November 7, 2019); a Home Health Certification and Plan of Care (dated November 15, 2019); Sunshine Health correspondence (dated September 9, 2019); a fax cover sheet (dated December 6, 2019); a fax transmission confirmation email (dated November 8, 2019); a fax cover sheet (dated November 19, 2019); 701B Comprehensive Assessment (dated August 26, 2020); a fax cover sheet (dated January 9, 2020); a Home Health Certification and Plan of Care (dated January 9, 2020); a fax cover sheet (dated March 9, 2020); a fax transmittal – prior authorization (dated January 13, 2020); a Home Health Certification and Plan of Care (dated March 9, 2020); a letter from [REDACTED] (dated April 7, 2020); a Home Health Certification and Plan of Treatment (start of care date: February 1, 2020); LTC Skilled Member Review Worksheet (dated July 7, 2020); Respondent correspondence (dated May 27, 2020); Respondent correspondence (dated May 28, 2020); Respondent correspondence (dated June 10, 2020); 701B Comprehensive Assessment (FLL TC) V 4 (dated June 26, 2020); LTSS Service Request v2 (complete date: August 21, 2020); an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); 701B Comprehensive Assessment (FLL TC) V 4 (dated August 26, 2020); Respondent fax transmittal (dated [REDACTED] 2020); 701B Comprehensive Assessment (dated August 26, 2020); email confirmation sheet (dated September 17, 2020); a fax cover sheet (dated September 17, 2020); a letter from [REDACTED] (dated September 17, 2020); LTSS Service Request v2 (complete date: September 24, 2020); 701B Comprehensive Assessment (FLL TC) V 4 (dated September 22, 2020); an NABD (dated September 24, 2020) (Plan ID: [REDACTED]); an NABD (dated September 24, 2020) (Plan ID: [REDACTED]);

[REDACTED]; Respondent letter (Unable to Process Appeal) (dated September 24, 2020); a fax cover sheet (dated September 28, 2020); a Home Health Additional Order (dated September 28, 2020); an NABD (dated October 2, 2020) (Plan ID: [REDACTED]); an NABD (dated October 2, 2020) (Plan ID: [REDACTED]); LTSS Service Request v2 (dated October 5, 2020); a fax cover sheet (dated October 13, 2020); a Home Health Additional Order (dated October 12, 2020); a fax cover sheet (dated October 19, 2020); a Home Health Additional Order (dated October 19, 2020); a Notice Of Appeal Or, In The Alternative, Request For Fair Hearing (signed November 18, 2020); an NABD (dated September 24, 2020) (Plan ID: [REDACTED]); an NABD (dated March 13, 2019) (Plan ID: [REDACTED]); excerpts from the 701B Comprehensive Assessment; an NPAR (Dated May 16, 2019) (Plan ID: [REDACTED]); an excerpt from the 701B Comprehensive Assessment; a letter from [REDACTED] (dated November 16, 2020); Medical records from [REDACTED] (dated [REDACTED] 2020, [REDACTED] 2020, and [REDACTED] 2020); 701B Comprehensive Assessment (FLL TC) V 4 (dated November 20, 2020); Medical records from [REDACTED] (dated [REDACTED] 2020); the 701B Comprehensive Assessment (dated November 20, 2020); an email between Respondent and [REDACTED] (dated January 19, 2021, through February 25, 2021); a fax cover sheet; Medical records from [REDACTED] (dated February 17, 2020, and February 20, 2020); Review Past Notes from [REDACTED] (dated [REDACTED] 2020); Medical records from [REDACTED] (dated [REDACTED] 2020); Karnofsky Performance Status Scale Definitions Rating (%) Criteria excerpt; Medical records from [REDACTED] (dated [REDACTED] 2020, [REDACTED] 2021); Respondent's member notes (June 17, 2020, through October 2, 2020); Service Authorization Summary (dated June 10, 2020); the LTC Ancillary Service Criteria; Fla. Admin. Code R. 59G-1.010;

LinkedIn Profile for [REDACTED]; LinkedIn Profile for [REDACTED]; LinkedIn Profile for [REDACTED]; and LinkedIn Profile for [REDACTED]

On April 12, 2021, Petitioner introduced an evidence packet containing thirty-one (31) pages, which was admitted into evidence as Petitioner's Composite Exhibit 9. Petitioner's Composite Exhibit 8 includes the following: an email from [REDACTED] (dated April 12, 2021); Petitioner's Response to Sunshine's April 9, 2021 Filing and Incorporated Fair Hearing Memorandum (dated and signed on April 12, 2021); and an email thread between [REDACTED], Hogan Lovells US LLP, and Sunshine Health (dates: December 16, 2020, through February 2, 2021).

On April 12, 2021, Respondent introduced an evidence packet containing thirty-one (31) pages, which was admitted into evidence as Respondent's Composite Exhibit 3. Respondent's Composite Exhibit 3 includes the following: an email from Hogan Lovells US LLP (dated April 9, 2021); Respondent's Reply to Petitioner's Response to February 5, 2021 Order to Show Cause (dated and signed on April 6, 2021); Exhibit A – an NABD (dated August 21, 2020) (Plan ID: [REDACTED]); Exhibit B – E-mail confirmation transmission (dated September 17, 2020); a fax cover sheet (dated September 17, 2020); a letter from [REDACTED] (dated September 17, 2020); and Exhibit C – a Sunshine Health letter (Unable to Process Appeal) (dated September 24, 2020).

FINDINGS OF FACT

1. As of [REDACTED], 2019, Petitioner is an enrolled member of Sunshine Health's Long-Term Care ("LTC") Program. See Respondent's Composite Exhibit 1, page 2. Sunshine Health is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.

2. At the time of the reconvened Fair Hearing on April 13, 2021, Petitioner is 34 years old and resides in the community with his mother, [REDACTED]. *Id.* at 60. Petitioner's father, [REDACTED], also resides with the Petitioner. *Id.* at 74. Petitioner's mother experiences physical and emotional crisis as Petitioner's primary caregiver. *Id.* Petitioner experiences the following health conditions: acid reflux/GERD; allergies; broken bones (C-5); high cholesterol; head, brain, or spinal cord trauma; constant bowel and bladder incontinence; and full paralysis. *Id.* at 65-66. Petitioner receives occupational therapy services and physical therapy services twice per week. *Id.* at 66. Petitioner receives 4 hours per day of Skilled Nursing services for bowel program, catheter use, and vital sign monitoring. *Id.* Petitioner is diagnosed with depression, anxiety, and post-traumatic stress disorder (PTSD). *Id.* at 67. Petitioner experiences severe muscle spasms at night and needs frequent positioning. *See* Petitioner's Composite Exhibit 7, page 39. The lack of repositions led to some recent falls and history of pressure wounds. *Id.* Petitioner experiences the following problems and interventions: fall prevention, bowel elimination alteration, urinary elimination alteration, skin integrity impairment/risk. *See* Petitioner's Composite Exhibit 8, pages 37-38. Petitioner is prescribed several medications. *Id.* at 43. Petitioner uses a wheelchair, a hospital bed, a commode, a Hoyer lift, and "air mattress, ramps." *Id.* at 43. Petitioner receives 28 hours per week of Skilled Nursing services rendered by an LPN. *Id.* at 44. Petitioner requires 1 person to assist with toileting, dressing, and bathing. *Id.* at 45.

3. Petitioner needs total assistance (cannot do at all) with Activities of Daily Living ("ADLs") such as bathing, dressing, transferring, and using the bathroom. *See* Respondent's Composite Exhibit 1, page 63. Petitioner needs supervision or prompt with eating. *Id.* Petitioner's uses an assistive device for walking/mobility. *Id.* Petitioner needs total assistance (cannot do at all) with

Instrumental Activities of Daily Living (“IADLs”) such as heavy chores, light housekeeping, preparing meals, shopping, managing medication, and using transportation. *Id.* at 64. Petitioner needs assistance (but not total help) with using the telephone. *Id.* Petitioner uses an assistive device and needs supervision or prompt with managing money. *Id.* [REDACTED] declared that the Petitioner is “totally dependent for all activities including transferring, bathing, grooming, dressing, eating, bowel regime twice daily, using condom catheter, bed and wheelchair bound.” See Petitioner’s Composite Exhibit 7, page 39.

4. [REDACTED] recommends 24/7 care for the Petitioner due to his quadriplegia. See Petitioner’s Composite Exhibit 7, page 39. [REDACTED] has been Petitioner’s primary care physician for 2 years. *Id.* [REDACTED] declared that the Petitioner has a specific bowel regimen “BID” twice per day. *Id.* at 46. [REDACTED] signed an Order for 28 hours per week of Attendant Care services. See Petitioner’s Composite Exhibit 8, page 316.

5. On March 13, 2019, Sunshine Health issued an NABD (Plan ID: [REDACTED] in AHCA Case Nos. 19-FH[REDACTED] and 19-[REDACTED]) denying Petitioner’s request for inpatient rehabilitation admission and an additional 84 hours per week of Personal Care services. See Petitioner’s Composite Exhibit 1, pages 27-30. On May 16, 2019, Sunshine Health issued an NPAR (Plan ID: [REDACTED] in AHCA Case Nos. 19-FH[REDACTED] and 19-[REDACTED]) denying Petitioner’s plan appeal for an additional 84 hours per week of Personal Care services. See Petitioner’s Composite Exhibit 1, pages 37-39. On June 11, 2019, Petitioner requested a Fair Hearing in AHCA Case Nos. 19-FH[REDACTED] and 19-[REDACTED]. On September 6, 2019, a Final Order was rendered in AHCA Consolidated Case Nos. 19-FH[REDACTED] and 19-[REDACTED] affirming, among other things, Sunshine Health’s denial of

Petitioner's request for an additional 84 hours per week of personal care services. See Petitioner's Composite Exhibit 8, pages 4-29.

6. On August 21, 2020, Sunshine Health issued an NABD terminating Petitioner's ten (10) hours per week of Respite Care services and 1 unit monthly of Personal Emergency Response System ("PERS") services. See Petitioner's Composite Exhibit 8, pages 148-156; see also Respondent's Composite Exhibit 1, page 10-18. The NABD states the following, in pertinent part:

Sunshine Health has reviewed your request for 10 hours per week of in [sic] respite care (the care given at your home to give your caregiver a break) and 1 unit monthly of personal emergency response service (a device that allows you to call for emergency help), which we received on 08/20/2020. After our review, this service has been:

TERMINATED as of 09/04/2020.

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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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:

...

Respite Care is approved short-term to provide the caregiver relief from care-giving duties. Your caregiver is able to be relieved of care-giver duties when home services aides are in the home. This decision was made with Sunshine Health Policy LT.UM.09 Long Term, Care Ancillary Service Criteria.

...

Right to Request a Plan Appeal

If your doctor wishes to discuss this decision with an appropriately licensed health care professional, he/she can call Sunshine Health at 1-866-796-0530.

If you do not agree with this decision, you have the right to request a plan appeal from Sunshine Health. When you ask for a plan appeal, Sunshine Health has a different health care professional review the decision that was made. You have the right to be represented by anyone you choose, including an attorney.

How to Ask for a Plan Appeal

You can ask for a plan appeal in writing or by calling us. Your care manager can help you with this, if you have one. We must receive the request within 60 days of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your Services to Continue" section below for details.) Here is where to call or send your request:

Sunshine Health
Appeal and Grievance Coordinator
1301 International Parkway, Suite 400
Sunrise, FL 33323
Phone: 1-866-796-0530 TTY/TDD 1-900-955-8770
Fax: 1-866-534-5972
Email: Sunshine_Appeals@Centene.com

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision

- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

...

What to Do if You Disagree with the Appeal Decision

The plan appeal process will result in a timely notice of plan appeal resolution (notice) that outlines the outcome of the plan appeal. If you still do not agree after you receive our notice, or if you do not receive the notice timely, you can ask for a fair hearing.

How to Ask for a Fair Hearing

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our notice of plan appeal resolution. **You must finish your appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration Medicaid Hearing Unit
P.O. Box 60127
Fort Myers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

...

Request for An Appeal or Grievance Form

If you want to request an appeal or grievance please complete this form. If you do not want to complete this form, you can write a letter that includes the information requested below.

...

[Member Name, ID #, Address, and Phone Number; NABD Reference Number; information supporting the appeal]

Member signature: _____ **Date:** _____

You may say that you want someone else to act for you. **This person must be someone who you have provided authorization to make appeal decisions for you.** If you do, you must let that person know and they must agree to do this for you. You can name a relative, friend, attorney, doctor, or someone else to act as your representative. **Both you and the person you want to act for you must sign and date a statement confirming this is what you want.**(emphasis added)

...

If you wish to have an authorized representative please print their name below:

Name:

Relationship to Member:

Authorized representative signature:

Date:

Remember: You must file an appeal within 60 calendar days of the date of the Adverse Benefit Determination letter. You can file a grievance at any time.

Id.

7. Sunshine Health's internal member notes (dated September 17, 2020) state the following with respect to Petitioner's provider, [REDACTED]:

APPEAL request from provider on member behalf via fax on 09/17/2020 regarding 10 hours per week of in respite care (the care given at your home to give your caregiver a break) and 1 unit monthly of personal emergency response service (a device that allows you to call for emergency help) Eligibility verified. Case (requested) during the appropriate time frame. Case UPL for no member consent. UPL letter and consent form faxed to the provider[.]

Respondent's Composite Exhibit 7, page 46.

8. On September 21, 2020 (at 2:39 p.m.), and on September 24, 2020 (at 11:35 a.m.), [REDACTED] [REDACTED] called Sunshine Health's Care Coordination ("CC") department regarding the termination of ten (10) hours per week of Respite Care services. See Petitioner's Composite Exhibit 7, page 47. Sunshine Health's notes state as follows:

CC received a call from members mother, wanting to know if the 10 additional hours were approved. CC explained the request to additional 10 hours has not yet been determined. [REDACTED] asked for CC to call her as soon as a decision is reached and CC agreed to do so. [REDACTED] stated PCP is faxing an order for 24/7 PC due to her and her husband having to get up during the night to assist member with repositioning, which is taking a toll on their health due to lack of sleep. CC stated CC will inform her when the order is received and the decision. No further questions or concerns at this time.

...

CC received a call from members mother, wanting to know if the 10 additional hours were approved, and if the appeal was received. CC informed her that yes, the appeal for termination of 10 in-home respite hours, PERS, and reduction of wipes was received via fax on 09/17/20. CC explained the request to additional 10

hours of PC takes 48 hours, and a decision should be made by tomorrow. [REDACTED] asked for CC to call her as soon as a decision is reached and CC agreed to do so. CC also reached out to supervisor to expedite the task.

Petitioner's Composite Exhibit 7, page 47.

9. On September 24, 2020 (at 5:02 p.m.), Sunshine Health issued a letter to [REDACTED] informing her that they were unable to process her request for a plan appeal on behalf of Petitioner regarding the termination of Respite Care services. See Petitioner's Composite Exhibit 6, page 11. The letter states as follows:

Dear [REDACTED]:

Sunshine Health received your request for an appeal as noted above. **We are unable to process your appeal or your request for continued services because a written request for an appeal from the member has not been received by Sunshine Health. This written request from the member is needed to process the appeal.**

If you have any questions about the Sunshine Health member appeal process please call the Sunshine Health Appeals and Grievance Department at 877-211-1999 or TDD/TYY at 800-955-8770 Monday through Friday, 8:00 a.m. to 5:00 p.m. (EST).

Sincerely,
DM
Appeals and Grievance Coordinator
Sunshine Health

Id.

10. On September 24, 2020, Sunshine Health issued an NABD denying Petitioner's request for an additional 10 hours per week of Personal Care services. See Petitioner's Composite Exhibit 8, pages 4-6. The NABD states as follows, in pertinent part:

Sunshine Health has reviewed your request for an extra 10 hours per week of Personal Care Services (the person who helps bathe and dress you), which we received on 9/17/2020. After our review, this service has been:

DENIED as of 09/24/2020.

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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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.

4. 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;
5. 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
6. 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:

3. Enable the enrollee to maintain or regain functional capacity; or
4. 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 10 hours per week of Personal Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 78 hours per week of Personal Care Services and 5 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id.

11. On October 2, 2020, Sunshine Health issued an NABD denying Petitioner's request for an additional 57 hours per week of Personal Care services. See Respondent's Composite Exhibit 2, pages 4-7. The NABD states as follows, in pertinent part:

Sunshine Health has reviewed your request for an extra 57 hours per week of personal care (the person who helps bathe and dress you), which we received on 09/28/2020. After our review, this service has been:

DENIED as of 10/02/2020.

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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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.

7. 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;
8. 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
9. 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:

5. Enable the enrollee to maintain or regain functional capacity; or
6. 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 57 hours per week of Personal Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs.

The member's present care plan includes:

- 28 hours per week of Attendant Care Services
- 78 hours per week of Personal Care Services
- 5 hours per week of Homemaker Services

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

Id.

12. On November 15, 2020, [REDACTED] completed Sunshine Health's Request for an Appeal or Grievance Form on behalf of Petitioner. See Petitioner's Composite Exhibit 1, page 9.

13. On November 18, 2020, [REDACTED] requested a Medicaid Fair Hearing on behalf of Petitioner based on Respondent's denial of an additional 10 hours per week of Personal Care services and Respondent's denial of an additional 57 hours per week of Personal Care services in AHCA Case Number 20-FH[REDACTED]. On November 18, 2020, [REDACTED] also requested a Medicaid Fair Hearing based on Respondent's termination of 10 hours per week of Respite Care services in AHCA Case Number 20-FH[REDACTED].

14. On December 11, 2020, Sunshine Health issued an NPAR denying Petitioner's plan appeal regarding Petitioner's request for an additional 10 hours per week of Personal Care services. See Respondent's Composite Exhibit 1, pages 89-91. The NPAR states as follows:

On November 18, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated September 24, 2020, Notice of Adverse Benefit Determination Number [REDACTED] denying **the Extra 10 hours per week of personal care** (the person who helps bathe and dress you), provided to [Petitioner].

On [REDACTED] 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 Extra 10 hours per week of personal care, effective [REDACTED] 2020.

The reason for our decision was: Based on the assessment of the member's care needs and household and caregiver status, the denial of an extra 10 hours/week of Personal Care Services is upheld. The presently approved home services are enough to meet the member's care needs. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

This decision was made by a Sunshine Health's Medical Director who is Board Certified in Internal Medicine, Geriatric Medicine, and Hospice & Palliative Care.

...

Sincerely,
John Carter, MD

Medical Director

Id. (Emphasis added).

15. Also, on December 11, 2020, Sunshine Health issued an NPAR denying Petitioner's plan appeal regarding Petitioner's request for an additional 57 hours per week of Personal Care services. See Respondent's Composite Exhibit 2, pages 89-91. The NPAR states as follows:

On November 18, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated October 2, 2020, Notice of Adverse Benefit Determination Number [REDACTED] denying **the Extra 57 hours per week of personal care** (the person who helps bathe and dress you), provided to [Petitioner].

On [REDACTED] 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 Extra 57 hours per week of personal care, effective [REDACTED] 2020.

The reason for our decision was: Based on the assessment of the member's care needs and household and caregiver status, the denial of the extra 57 hours/week of Personal Care Services is upheld. The presently approved services are enough to meet the member's care needs. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

This decision was made by a Sunshine Health's Medical Director who is Board Certified in Internal Medicine, Geriatric Medicine, and Hospice & Palliative Care.

...

Sincerely,
John Carter, MD
Medical Director

Id. (Emphasis added).

16. On December 11, 2020, the undersigned consolidated AHCA Case Number 20-FH [REDACTED] and AHCA Case Number 20-FH [REDACTED] to promote the just, speedy, and inexpensive resolution of the proceedings without prejudicing the rights of any party.

17. On December 15, 2020, the undersigned issued an Order to Show Cause to Petitioner regarding the NABD dated September 24, 2020 (Plan ID: [REDACTED]) denying Petitioner's request (requested on September 24, 2020) for an additional 10 hours per week of Personal Care services, and the NABD dated October 2, 2020 (Plan ID: [REDACTED]) denying Petitioner's request (requested on September 28, 2020) for an additional 57 hours per week of Personal Care services, ordering Petitioner to submit to the Office, on or before December 28, 2020, an NPAR or other documentation or explanation to show cause why the request for a Fair Hearing should not be dismissed for failure to complete the plan appeal process pursuant to Fla. Admin. Code R. 59G-1.100(8).

18. On December 15, 2020, the undersigned also issued an Order to Show Cause to Petitioner regarding the NPAR (Plan ID: [REDACTED]), ordering Petitioner to submit to the Office, on or before December 28, 2020, documentation to show cause why the request for a Fair Hearing should not be dismissed under Fla. Admin. Code R. 59G-1.100(18)(h) on grounds of Res Judicata.

19. On December 15, 2020, the undersigned issued an Order Scheduling Preliminary Hearing by Telephone and Prehearing Instructions ("Scheduling Order") to both parties, scheduling a preliminary hearing to be conducted by telephone on January 11, 2021, at [REDACTED]

20. In making a medical necessity determination in the NABD and in the NPAR, Sunshine Health relied upon their LTC Ancillary Service Criteria. See Respondent's Composite Exhibit 1, pages 95-126. Sunshine Health's LTC Ancillary Service Criteria states as follows:

1. Determinants for Services

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)

- Independent where member is able to provide the task without support, with or without assistive devices
- Minimal functional impairment where the ADL's require one of the following:
 - Supervision
 - At least minimum assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance
- Moderate functional impairment where two of the follow apply
 - Member has ADLs requiring at least minimal assistance
 - Member ambulates with assistance of a person or device
 - Member transfers require at least minimum assistance
- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
 - Member has ADLs requiring total assistance
 - Member is non-ambulatory
 - Member transfers require one (1) to two (2) person assist
 - Member's treating physician has certified that member meets Maximum functional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member). Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

The criteria for each ancillary service is described below:

...

7. Personal Care Services

A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- c. Assisting the member in following through with physician orders The Personal Care provider cannot not administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times
- d. Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member
- e. Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location.

Approval Criteria

Personal Care Services reviews include four (4) criteria:

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

See Section C.1 for more detail

Covered Personal Care services may include:

- a) Bathing - Assistance with bathing, including washing, rinsing, and drying the body or body parts.
 - Member's ability to transfer in and out of the tub or shower
 - Amount of time it takes the member to transfer in and out of the tub or shower
 - Ability of member to prepare the shower or run the bath water
 - Ability of member to use any assistive devices, such as a grab-bar or shower chair
 - Ability of member to use a sponge or wash cloth to clean himself/herself
 - How many times per week does the member bathe, consider that:
 - Incontinence episodes resulting in the need for a bath
 - Daily bathing of the elderly is not recommended due to damage that occurs to the skin from the water and the soap
 - Bathing more than once per day is a personal preference and not a necessity.
 - Full bath (bathtub, shower, or bed bath) or partial sponge bath (washing of face, underarms, and private areas).
 - A bed bath for members who are bed bound and cannot get out of the bed to be bathed in a shower or tub

- b) Dressing and Grooming - Dressing assistance includes the laying out, taking off, putting on, and fastening of clothing and footwear, and includes:
 - Member's ability to choose their own clothes, put them on, and put on socks and shoes
 - Ability to put clothes, socks and shoes on if someone lays out the clothes
 - Ability to button, zipper, tie, or buckle clothes or shoes
 - Ability to successfully use assistive devices in dressing, such as reachers, sock pullers, or shoehorns
 - Ability to dress self in the morning or evening to get ready for bed

Grooming includes assessment of member's ability to:

- Comb or brush hair
- Shave

- Complete oral hygiene, including brushing teeth, remove dentures/partials, clean dentures/partials, and replace dentures/partials
 - Trim and clean fingernails and toenails
 -
- c) Eating and Feeding Considerations – Eating/Feeding is the process of a member getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into their body after it is cooked or prepared for eating. (This does not include tube feeding as that is considered a skilled task.) Includes an assessment of the member’s ability to:
- Cut foods into appropriate size pieces
 - Move food or drink from the serving receptacle to their mouth
- Support for eating considers the number of meals per day that the member eats.
- Note: Assistance with the preparation of meals is considered as part of Meal Preparation
- d) Toileting Considerations
- Taking off and putting on of clothing and/or diapers,
 - Post-toilet hygiene
 - Use of equipment, such as a urinal or bedpan
 - Emptying of urinal or bedpan
 - Cleaning of a catheter or ostomy bag
 - Reminders or a toileting schedule
- e) Transferring Considerations - Transferring is the member’s ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. It includes an assessment of the member’s:
- Ability to use any mechanical devices such as a walker, cane, handrails, or wheelchair to assist with transfers
 - Ability to safely transfer without the assistance of another person
 - Ability to physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver
- f) Mobility Considerations – Mobility is the extent of the member’s purposeful movement within their residence. It includes an assessment of the member’s:
- Ability to purposely move about his/her residence independently with or without the use of assistive devices, this includes the ability of a member to move around in a wheelchair
 - Movements being unsafe without the assistance of another person in ambulating
 - Muscle weakness, unstable gait or unstable balance

...

Exclusions and Limitations for Personal Care services include but are not limited to:

1. Service must be provided at member's residence.
2. Member must reside in a non-facility based setting.
3. The provider must be awake during the provision of personal care services.
4. If services are required overnight, member must live alone and one of the following conditions must apply:
 - a. Member requires frequent repositioning due to wounds
 - b. Severe incontinence requiring multiple overnight changes and cleaning
5. Services provided by Sunshine Health may not duplicate services that are provided under by another provider.
6. Escort Services

Respondent's Composite Exhibit 1, pages 96-126.

21. On February 5, 2021, the undersigned scheduled a Fair Hearing to be conducted by telephone for March 9, 2021, at [REDACTED]. On March 2, 2021, the undersigned granted Petitioner's request for a continuance upon a showing of good cause. On March 5, 2021, the undersigned rescheduled the Fair Hearing to be conducted by telephone for April 8, 2021, at [REDACTED]. On March 11, 2021, the undersigned granted Petitioner's request for another continuance upon a showing of good cause and rescheduled the Fair Hearing to be conducted by telephone for April 13, 2021, at [REDACTED].

22. At the preliminary hearing and at the Fair Hearing, both parties agreed that [REDACTED] requested a plan appeal on behalf of Petitioner. However, Respondent asserted that the plan appeal request was not processed because [REDACTED] was not an Authorized Representative of the Petitioner at the time the request was made. Counsel for Petitioner, [REDACTED], presented no evidence that [REDACTED] completed an Authorized Representative Form to request a plan appeal on behalf of the Petitioner. [REDACTED] argued that [REDACTED] call to Respondent for a status update on [REDACTED] plan appeal request should constitute a valid plan

appeal request as well. [REDACTED] did not allege that [REDACTED] formally requested a plan appeal, but rather that Respondent misled [REDACTED] into believing there was no issue with [REDACTED] plan appeal request and failed to thoroughly inform her of Petitioner's rights and options. Counsel for Respondent, Attorney Comparato, admitted on the record that Respondent could have been clearer in its telephonic communication with [REDACTED]. Attorney Comparato argued that [REDACTED] telephone calls did not constitute a formal request for a plan appeal because [REDACTED] is not an Authorized Representative and did not complete an Authorized Representative Form, or similar documentation, on behalf of Petitioner. [REDACTED] did not present evidence that [REDACTED] completed an Authorized Representative Form and formally requested a plan appeal regarding the termination of Respite Care services. At the preliminary hearing and under oath, Ms. Layne testified that Sunshine Health's Grievance and Appeals department did not receive a request for a plan appeal regarding the termination of Respite Care services. Ms. Layne is the Senior Manager Member Appeals and all requests for plan appeals come to her department at Sunshine Health. Ms. Zwegers testified that Sunshine Health processed a new service request based on a conversation with Petitioner regarding their needs and assessment of the type of services Petitioner may need. At the preliminary hearing and under oath, Ms. Layne testified that Sunshine Health's Grievance and Appeals department did not receive a request for a plan appeal regarding the termination of Respite Care services. Ms. Resch Care Coordinator for Sunshine Health, testified that [REDACTED] never submitted a Power of Attorney on behalf of Petitioner to make her an Authorized Representative. [REDACTED] is a designated representative to make financial decisions on behalf of the Petitioner, when he is incapable of doing so, but she is not an Authorized Representative of the Petitioner. As testified

to by Ms. Pacheco, all of Sunshine Health's NABDs have a specific form attached allowing the Medicaid recipient to make someone else an Authorized Representative regarding appealing adverse actions taken against a recipient's services. [REDACTED] never completed Sunshine Health's Authorized Representative Form prior to, or after, calling Sunshine Health to inquire about [REDACTED] provider appeal.

23. At the Fair Hearing and under oath, [REDACTED] confirmed that she has been a CNA for the past 25 years and has cared for the Petitioner for the past 30 months. [REDACTED] rendered LTC services to the Petitioner during the day and during the evening. [REDACTED] last rendered LTC services to Petitioner on February 18, 2021. [REDACTED] recommends 24-hour care to assist Petitioner with hands-on care based on her professional experience and personal work history as the Petitioner's caregiver. Based on [REDACTED] 30 months of services to the Petitioner, he cannot complete ADLs without assistance. [REDACTED] observed Petitioner's leg spasms during the day and in the evening while Petitioner is asleep. [REDACTED] observed Petitioner's parents being unable to assist the Petitioner with hands-on care. Petitioner uses a "condom catheter" for urination, and Petitioner experiences complications with the "condom catheter" several times during the day and evening, on a daily basis. When the "condom catheter" falls out, Petitioner will urinate "all over the bed." Petitioner has a history of bed sores. Petitioner is a risk of falling out of bed if left unattended due to how strong his leg spasms are when they occur. Petitioner sometimes does not go to bed until 3:00 a.m. or 4:00 a.m. [REDACTED] reported Petitioner's falls to her Home Health Agency (her employer), but does not know if the Home Health Agency reported the falls to Sunshine Health. [REDACTED] is not present in the home with Petitioner is receiving Skilled Nursing services. [REDACTED] work schedule was as follows: Saturday

morning shift, Saturday evening shift, Sunday morning shift, Sunday evening shift, Monday morning shift, Monday evening shift, and Tuesday morning shift.

24. At the Fair Hearing and under oath, Petitioner confirmed that he is 34 years old and chooses to reside in the community, and not be institutionalized. Petitioner has experienced staffing issues due to the reduced LTC hours and speculated that he will experience bodily injury if left unattended or if he does not have a competent caregiver. Petitioner experiences anxiety when he does not receive adequate care.

25. At the Fair Hearing and under oath, Ms. Fox confirmed that, in August 2020, she completed the LTSS Service Request Form that led to the review and the subsequent termination of Petitioner's Respite Care services. A Sunshine Health representative requested a SNAP Review of Petitioner's LTC services; Ms. Fox does not know the name of the Sunshine Health representative that requested the SNAP Review. Petitioner did not request the SNAP review. SNAP Review is a Care Plan Review implemented by Sunshine Health's Utilization Management department. Sunshine Health conducts SNAP Reviews on their enrollees periodically, three or four times per year. Ms. Fox had a conversation with Petitioner and explained to him that Respite Care services were terminated because Respite Care services are only intended for temporary use. During the telephone conversation, Ms. Fox recommended that Petitioner consider an Assisted Living Facility, but did not recommend a Nursing Facility.

26. At the Fair Hearing and under oath, Ms. Zwegers confirmed that she is the supervisor of Case Management for Sunshine Health and has been an employee of Sunshine Health for the past 5 years. Ms. Zwegers is the direct supervisor of Tracey Resch and Amanda Fox. Based on Ms. Fox's telephone conversation with the Petitioner and [REDACTED], Ms. Zwegers directed Ms. Fox

to process a request for additional Personal Care services versus a request for a plan appeal regarding the termination of Respite Care services. Sunshine Health reasoned that Petitioner, and his mother, were concerned for a lack of hands-on care on the weekends and identified the appropriate category of LTC services available to the Petitioner.

27. At the Fair Hearing and under oath, Dr. Carter confirmed that he has been a LTC Medical Director with Sunshine Health since August 2014. Dr. Carter is board-certified in internal medicine, geriatric medicine, and hospice & palliative medicine. Dr. Carter reviewed information submitted by the Case Manager and Sunshine Health's Utilization Management department prior to making a medical necessity determination regarding the request for an additional 10 hours per week of Personal Care services and an additional 57 hours per week of Personal Care services. Dr. Carter considered Petitioner's currently authorized LTC services and Petitioner's needs for assistance in making his medical necessity determination. Petitioner's request for an additional Personal Care services was denied based on the 701B Comprehensive Assessment. At the time of this request, Petitioner was authorized to receive 28 hours per week of Attendant Care services, 78 hours per week of Personal Care services, and 5 hours per week of Homemaker services. Dr. Carter identifies the Petitioner as, "very severely disabled." Dr. Carter was not the initial medical director who issued the NABD but did issue the NPAR after a plan appeal review. Dr. Carter reviewed the 701B Comprehensive Assessment in making medical necessity determination. Dr. Carter reviewed other "clinical documentation," but when given the opportunity to identify what this information is, Dr. Carter could not identify the documentation, nor could he confirm whether this clinical documentation was submitted for the Fair Hearing and could not locate any such clinical documentation in any of Respondent's submitted evidence

packets. Dr. Carter confirmed that a caregiver experiencing crisis is considered in making medical necessity determinations, as well as a caregiver's inability to provide care. Dr. Carter reviewed [REDACTED] letter of recommendation and considered it in his medical necessity determination.

28. At the Fair Hearing and under oath, Ms. Resch confirmed that she is Petitioner's Care Coordinator at Sunshine Health, and has been a Registered Nurse (RN) for the past 37 years. Ms. Resch specializes in working with quadriplegic and ventilator dependent Sunshine Health enrollees. Ms. Resch has never spoken directly to the Petitioner, but has spoken with Petitioner's parents. Ms. Resch has not had a face-to-face visit with the Petitioner. Petitioner's current LTC services are rendered as follows: Midnight – 6:00 am; and 10:00 am – 6:00 pm. Petitioner has not distributed his LTC services during the evening hours. Petitioner has a Licensed Practical Nurse (LPN) rendering Attendant Nursing Care services daily. Ms. Resch was aware that [REDACTED] has medical conditions, but no documentation was received regarding the physical limitations of Petitioner's parents; Sunshine Health did not request that they submit any medical records regarding physical limitations. Ms. Resch was never informed that Petitioner experienced any falls at night. Ms. Resch was not informed that Petitioner gets out of bed at night. Ms. Resch has no knowledge of any complications Petitioner experiences at night.

CONCLUSIONS OF LAW

29. Pursuant to Florida Statute ("Fla. Stat.") § 409.285(2) (2019), the Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This Final Order is the final administrative decision of AHCA. *See* Fla. Stat. § 409.285(2)(a).

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

31. Because Petitioner is asserting the affirmative of an issue and requesting new services, the burden of proof on all four issues is on the Petitioner. See Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

32. Fla. Admin. Code R. 59G-1.100 establishes procedures applicable to Fair Hearings conducted by the Agency, pursuant to Fla. Stat. § 409.285(2).

Petitioner’s Compliance with Fla. Admin. Code R. 59G-1.100(8)(e).

33. The Agency has jurisdiction and must provide a Fair Hearing for:

(3) Jurisdiction and Right to a Hearing.

The Agency has jurisdiction and must provide a fair hearing for:

(a) A FFS recipient who makes a hearing request regarding:

1. The reduction, suspension, or termination by the Agency of a previously authorized service,
2. The denial, in whole or in part, of a requested service or supply by the Agency, or
3. The failure of the Agency to provide a timely NOA subsequent to the Agency’s failure to provide all medically necessary services to the recipient with reasonable promptness.

(b) An enrollee who makes a hearing request regarding:

1. A notice of plan appeal resolution indicating that the plan appeal did not result in the reversal of a prior denial of a new service, or the reduction, suspension, or termination of a previously authorized service, if timely challenged by the enrollee in accordance with the plan appeal procedures following the timely issuance of the plan’s NABD to the enrollee,
2. The failure of the plan to adhere to notice and timing requirements applicable to plan appeals, or
3. The failure of the plan to timely notice the enrollee through a NABD, subsequent to the plan’s failure to provide medically necessary services requested by the enrollee to the enrollee with reasonable promptness.

(c) An enrollee who makes a hearing request regarding a disenrollment denial.

(d) A recipient who receives notification from the Agency pursuant to rule 59G-5.110, F.A.C., that a reimbursement request is denied in whole or in part.

(e) A recipient entitled to a fair hearing pursuant to section 409.285(2), F.S.

- (f) The Agency need not grant a fair hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
- (g) A recipient who makes a hearing request regarding a denial or reduction to a medically necessary Florida Medicaid service and seeks corrective action.

34. An enrollee must initiate and complete a plan appeal before making a fair hearing request. The plan appeal is complete when: (1) the enrollee receives from the plan a NPAR indicating the plan appeal was not resolved wholly in the enrollee's favor, or (2) the plan fails to adhere to notice and timing requirements applicable to plan appeals. See Fla. Admin. Code R. 59G-1.100(8)(e).

35. A plan appeal is a review by the Plan of an adverse benefit determination. The Enrollee may request a plan appeal by following the instructions at the bottom of the NABD dated September 24, 2020 (Plan ID: ██████████), and the NABD dated October 2, 2020 (Plan ID: ██████████). Once the Plan makes a determination regarding the plan appeal, it issues to the Enrollee an NPAR. The NPAR explains how to ask for a Fair Hearing if the Enrollee does not agree with the decision.

36. Because completion of a plan appeal is a jurisdictional requirement for the Office, Fla. Admin. Code R. 59G-1.100(9)(b)(2) authorizes a Hearing Officer to deny or dismiss a request for a Fair Hearing if the Enrollee has not completed the plan appeal. Dismissal is without prejudice so that the Petitioner may properly request a Fair Hearing after completion of the plan appeal.

37. The Office may consider a plan appeal to be complete if the Plan fails to adhere to notice and timing requirements applicable to plan appeals. This information should be provided in Sunshine Health's NABD.

38. On December 15, 2020, the undersigned Hearing Officer issued an Order to Show Cause, ordering the Petitioner to submit to the Office, on or before December 28, 2020, an NPAR or

other documentation or explanation to show cause why the request for a Fair Hearing should not be dismissed for failure to complete the plan appeal process. The Order stated that failure to comply with this order will result in dismissal of the aforementioned matters.

39. In this case, Respondent issued an NABD terminating 10 hours per week of Petitioner's Respite Care services. *See supra* ¶ 6. The Office of Fair Hearings does not have on file an NPAR indicating that the plan appeal process has been completed. Respondent's position is that the Petitioner did not properly request a plan appeal regarding the termination of 10 hours per week of Respite Care services. *See supra* ¶ 22. Petitioner presented two instances, which they argue constitute a plan appeal request and, as a result of not processing a plan appeal, Petitioner argues that Respondent did not adhere to notice and timing requirements applicable to plan appeals. *See supra* ¶ 22. These instances include: (1) [REDACTED] written request for a plan appeal on September 17, 2020; (2) [REDACTED] telephone call to Respondent on September 21, 2020, and September 24, 2020, inquiring about the termination of Respite Care services. *See supra* ¶ 22.

40. With respect to [REDACTED] written request, Respondent determined that they were unable to process a plan appeal because [REDACTED] was not an Authorized Representative of the Petitioner. *See supra* ¶ 22. Simply, Respondent indicated that they did not have consent from the Petitioner for [REDACTED] to request of a plan appeal on his behalf. The NABD issued on August 21, 2020, sets forth instructions for requesting a plan appeal. Included with the NABD is a Request for an Appeal or Grievance Form. *See supra* ¶ 9. The NABD states that Petitioner can request an appeal by using the Appeal or Grievance Form or by writing a letter that provides the same information requested in the Form. *See supra* ¶ 6 and 22. Respondent issued a notice to [REDACTED] on September 24, 2020, indicating that Respondent was unable to process Petitioner's

plan appeal request. See supra ¶ 9. The record does not indicate that ██████ completed and submitted an Authorized Representative Form, or similar documentation, to Respondent. At the hearing, ██████ argued that Respondent had a duty to thoroughly and proactively inform Petitioner why ██████ plan appeal request was not processed, and what was needed to process the plan appeal request.

41. With respect to ██████ two telephonic calls to Sunshine Health, Respondent determined that a plan appeal was not requested during this time because ██████ was not an Authorized Representative as well and did not formally request a plan appeal, but rather called to inquire about ██████ plan appeal request. Respondent's records do not indicate that Petitioner's mother, ██████ requested a plan appeal during this time. In addition, the record does not indicate that ██████ completed an Authorized Representative Form, or similar documentation, to represent the Petitioner with Sunshine Health regarding service requests. Petitioner did not present any evidence to indicate that ██████ completed an Authorized Representative Form, or that she formally requested a plan appeal on September 21, 2020, or September 24, 2020. At the hearing, ██████ also argued that Respondent had a duty to thoroughly and proactively inform Petitioner and ██████ during their telephonic conversation that ██████ plan appeal request was insufficient, and what was needed to process the plan appeal request. ██████ also argued that Respondent misled ██████ and Petitioner into believing that there was no issue with ██████ plan appeal request. At the hearing, Attorney Comparato admitted that Respondent could have been clearer in communication, but argued that they did not mislead or misrepresent the situation to Petitioner or ██████. Again, although Respondent could have done more to inform and guide ██████ and the Petitioner

during the plan appeal process, the record does not indicate that they had an obligation to do so or that Respondent misrepresented any facts to them. Subsequently, the record indicates that Respondent's determination that [REDACTED] plan appeal request was insufficient occurred after [REDACTED] two telephone conversations with Respondent. See supra ¶¶ 8-9, 22. Thus, at the time the conversations took place, a decision regarding the legal sufficiency of [REDACTED] plan appeal request was not yet made. Because [REDACTED] provided no testimony at the hearing regarding the telephonic conversations that took place with Respondent, the record only corroborates Respondent's account of the conversation. The record does not indicate that [REDACTED] two telephone calls to Sunshine Health constitute a plan appeal request. The record reflects that Petitioner did submit a Request for an Appeal or Grievance Form, signed by Petitioner and designating [REDACTED] as Authorized Representative. However, this Form was not submitted to Sunshine until November 15, 2020, which is eighty-six (86) days after the NABD concerning the termination of Respite Care services was issued. See Petitioner's Composite Exhibit 1 at page 9-10. The NABD notified Petitioner that Sunshine must receive the request for a plan appeal "within 60 days of the date of this letter." See supra ¶ 6. Accordingly, the November 15, 2020, appeal request was an untimely plan appeal.

42. Accordingly, upon consideration of the record, the parties' sworn testimony, the parties' evidence admitted into the record, and the aforementioned applicable laws and policies, the undersigned concludes that Petitioner's request for a Fair Hearing did not comply with the Office's timing requirements, as provided in Fla. Admin. Code R. 59G-1.100(8)(e). Thus, Petitioner has not established that Petitioner properly requested a plan appeal regarding the termination

of Respite Care services or that Respondent failed to adhere to notice and time requirements related to plan appeals.

Petitioner's Compliance with Fla. Admin. Code R. 59G-1.100(18)(h).

43. The United States Supreme Court has explained that, "subject to certain well-known exceptions, the general rule is that '[w]hen an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim.' " *B & B Hardware , Inc. v. Hargis Indus., Inc.*, 135 S.Ct. 1293, 1303 (2015) (*citing* Restatement (Second) of Judgments§ 27, p. 250 (1980)). In other words, rehearing of issues of fact or law is prohibited if the parties already had an opportunity to litigate those issues and a valid and final determination was made with respect to those issues.

44. The Supreme Court went on to explain:

[I]n those situations in which Congress has authorized agencies to resolve disputes, "courts may take it as given that Congress has legislated with the expectation that the principle [of issue preclusion] will apply except when a statutory purpose to the contrary is evident." . . . This reflects the Court's longstanding view that "(w]hen an administrative agency is acting in a judicial capacity and resolves disputed issues of fact properly before it which the parties have had an adequate opportunity to litigate, the courts have not hesitated to apply res judicata to enforce repose."

Id. (*citing Astoria Fed. Sav. & Loan Assn. v. Solimino*, 501 U.S. 104, 108 (1991) & *University of Tenn. v. Elliott*, 478 U. S. 788, 797- 798(1986)).

45. Fla. Admin. Code R. 59G-1.100(18)(h) states that "[r]ehearing or reconsideration of a Final Order is prohibited under this rule." Consistent with Res Judicata, this prevents duplicative testimony and judgments made with respect to a Final Order already rendered.

46. Based on information contained in the Office of Fair Hearings' case management system, on June 11, 2019, Petitioner requested a Fair Hearing based on Respondent's denial of Petitioner's request for eighty-four (84) hours per week of Personal Care services. The case was assigned AHCA Case Numbers 19-FH [REDACTED] and 19-[REDACTED]. The NPAR (Plan ID: [REDACTED]) in the case was dated May 16, 2019, and the NABD (Plan ID: [REDACTED]) was dated March 13, 2019. In the instant case, Petitioner requested a Fair Hearing on November 18, 2020, regarding the same NABD and the same NPAR. Because a Final Order was rendered on September 6, 2019, after a full evidentiary Fair Hearing, the undersigned concludes that Fla. Admin. Code R. 59G-1.100(18)(h) bars rehearing of this matter.

47. On December 15, 2020, the undersigned Hearing Officer issued an Order to Show Cause, ordering the Petitioner to submit to the Office, on or before December 28, 2020, documentation to show cause why the request for a Fair Hearing should not be dismissed under Fla. Admin. Code R. 59G-1.100(18)(h). Failure to comply with this order will result in dismissal of the aforementioned matter.

48. At the preliminary hearing, [REDACTED] asserted that the request for a Medicaid Fair Hearing regarding the Petitioner's request for 84 hours per week of Personal Care services was a mistake. [REDACTED] asserted that the information submitted regarding Petitioner's request for 84 hours per week of Personal Care services was only submitted for context regarding Petitioner's past history with Respondent. [REDACTED] confirmed Petitioner did not intend to pursue the rehearing of a previously issued Final Order.

49. Accordingly, upon consideration of the record, the parties' sworn testimony, the parties' evidence admitted into the record, and the aforementioned applicable laws and policies, the

undersigned concludes that show cause why the request for a Fair Hearing should not be dismissed under the doctrine of Res Judicata and Fla. Admin. Code R. 59G-1.100(18)(h).

Respondent's denial of fifty-seven (57) hours per week of Personal Care services and Respondent's denial of ten (10) hours per week of Personal Care services

50. Because Petitioner requested new services, the burden of proof is on the Petitioner. See Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

51. Pursuant to Fla. Admin Code R. 59G-1.100(17)(g), the burden of proof is 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.

(Emphasis added).

52. The Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017), incorporated by reference in Fla. Admin. Code R. 59G-4.192, establishes the provision and coverage for LTC services available under the Florida Medicaid program. The LTC Policy states the following:

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.

...

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the 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 restrictive setting

...

4.2.1 Home and Community-Based Supportive Services

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

4.2.1.1 Adult Companion Care

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

4.2.1.9 Homemaker Services

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

4.2.1.14 Personal Emergency Response Systems [“PERS”]

For installation and service monitoring of an electronic device connected to an enrollee’s phone that includes a portable “help” button, when provided to an enrollee at high risk of institutionalization to secure help in an emergency.

4.2.1.15 Respite Care

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee’s natural supports on a planned or an emergency basis.

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

4.2.2.2 Attendant Nursing Care

In accordance with Rule 59G-4.261, F.A.C., for enrollees under the age of 21 years. To provide nursing care of both a supportive and health related nature, specific to the needs of a medically stable, physically handicapped enrollee age 21 and older who requires more individual and continuous care than an intermittent nursing visit. The scope and nature of these services do not otherwise differ from private duty nursing services furnished to persons under the age of 21 years.

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.

53. The Florida Medicaid Definitions Policy (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines the commonly used terms, Medical Necessity and Medically Necessary, 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.

(Emphasis added).

54. Based on the NABD issued on October 2, 2020, and the NPAR issued on December 11, 2020, Respondent denied Petitioner's request for an additional 57 hours per week of Personal Care services, based on medical necessity. *See supra* ¶ 11, 15. Thus, Respondent ultimately determined that requested Personal Care services were in excess of Petitioner's needs. *See supra* ¶ 11, 15. Specifically, Respondent determined that, "[b]ased on the assessment, the member's currently approved services are adequate to meet the member's care needs." *See supra* ¶ 11. At the time of the adverse action, Petitioner's currently approved services are 28 hours per week of Attendant Care services, 78 hours per week of Personal Care services, and 5 hours per week of Homemaker services. *See supra* ¶ 11.

55. Both the NABD and the NPAR disclosed that the adverse action taken against Petitioner's request for additional Personal Care services were made with the LTC Ancillary Service Criteria.

See supra ¶ 11, 15. The LTC Ancillary Service Criteria for Personal Care services weighs four (4) criteria: (a) ADL limitations; (b) Living situation; (c) Supervision needs; and (d) Available Support. See supra ¶ 20. Petitioner is fully paralyzed with constant bowel and bladder incontinence. See supra ¶ 2. Petitioner experiences severe muscle spasms at night and needs frequent positioning, has had some recent falls, and has a history of pressure wounds. See supra ¶ 2. Petitioner needs total assistance with most ADLs. See supra ¶ 3. Petitioner resides in the community with both parents. See supra ¶ 3. Petitioner's parents are no longer able to assist the Petitioner with ADLs. See supra ¶ 23. Petitioner needs supervision with eating. See supra ¶ 3. Petitioner ambulates with the assistance of a person or device. See supra ¶ 23. Petitioner requires assistance with transfers. See supra ¶ 32. Petitioner requires some supervision. See supra ¶ 23. Petitioner receives 111 hours per week of LTC services (approximately 15 hours per day). See supra ¶ 10.

56. Personal Care services "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 ¶ 52. Personal Care services are covered if they are determined to be medically necessary. Because Personal Care services are classified as mixed services, the Definition Policy's definition of medical necessity applies. See supra ¶ 52. To be medically necessary, a service must meet the criteria set forth in the section 2.83 of the Definitions Policy. Based on the record, *supra* ¶ 11 and 15, Respondent denied Petitioner's request for not meeting the following medical necessity criterion: Services must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

57. With respect to Medical Necessity, the record indicates that the Petitioner requested the additional Personal Care services to be rendered during the evenings. Petitioner proved by a preponderance that the additional 57 hours per week of Personal Care services are not in excess of the Petitioner's needs at this time. [REDACTED], Petitioner's previous Home Health Aide, presented credible testimony that the Petitioner requires hands-on care while asleep in the evening due to severe bodily spasms that the Petitioner cannot control due to full paralysis. See supra ¶ 23. In addition, the Petitioner requires hands-on assistance with his "condom catheter" used for urination. See supra ¶ 23. Petitioner is a risk of falling out of bed due to uncontrollable bodily spasms. See supra ¶ 23. Respondent's LTC Medical Director classifies the Petitioner as "very severely disabled." See supra ¶ 27. Petitioner's parents experience crisis and can no longer render natural support to the Petitioner. See supra ¶ 2. Respondent argued that Petitioner may reallocate his currently approved LTC services to render care in the evenings, so that his needs are met. However, the record indicates that the Petitioner cannot reallocate his currently approved LTC services to render care in the evenings because they are currently allocated and used during the daytime hours. See supra ¶ 23, 28. Petitioner's current LTC services are rendered as follows: 12:00 a.m. – 6:00 a.m.; and 10:00 a.m. – 6:00 p.m. See supra ¶ 28. Respondent also argued that the Petitioner may consider enrollment into an Assisted Living Facility (ALF), if he needs 24-hour care. However, Petitioner elects to reside in the community. See supra ¶ 24. Respondent argued that much of the information regarding Petitioner's needs were not provided to the Respondent prior to the issuance of the NABD and the NPAR, while Petitioner argued that much of the information that Respondent relied upon while issuing the NABD and the NPAR was incorrect. Given that the Petitioner has need for assistance with ADLs from 6:00 a.m. – 10:00 a.m.

and 6:00 p.m. – Midnight, daily, Petitioner does not have LTC services to cover these hours, and Petitioner’s family cannot provide natural support, the record indicates that the Petitioner has an unmet need for additional Personal Care services. The aforementioned testimony elicited and the documentary evidence established that the specific quantity of Personal Care services, 57 hours per week, is medically necessary for the Petitioner. Based on the record, Petitioner has demonstrated the additional 57 hours per week of Personal Care services are not in excess of Petitioner’s needs at this time. Thus, the Petitioner meets criterion number two for medical necessity.

58. Subsequently, based on the NABD issued on September 24, 2020, and the NPAR issued on December 11, 2020, Respondent denied Petitioner’s request for an additional 10 hours per week of Personal Care services, based on medical necessity. *See supra* ¶ 10, 14. Thus, Respondent ultimately determined that requested Personal Care services were in excess of Petitioner’s needs. *See supra* ¶ 10, 14. Specifically, Respondent determined that, “[b]ased on the assessment, the member's currently approved services are adequate to meet the member's care needs.” *See supra* ¶ 10. At the time of the adverse action, Petitioner’s currently approved services are 28 hours per week of Attendant Care services, 78 hours per week of Personal Care services, and 5 hours per week of Homemaker services. *See supra* ¶ 10. This equals 111 hours per week out of a possible 168 hours per week of LTC coverage.

59. As previously established, Petitioner requires total assistance with most ADLs and no longer has the natural support of his parents. Further, Petitioner has need for assistance with ADLs from 6:00 a.m. – 10:00 a.m. and 6:00 p.m. – Midnight, daily, Petitioner does not have LTC services to cover these hours, and Petitioner’s family cannot provide natural support, the record

indicates that the Petitioner has an unmet need for additional Personal Care services. However, the LTC Policy and the Florida Medicaid program bars the approval of services that duplicate another service. See supra ¶ 52. In this instance, with the approval of the previously requested additional 57 hours per week of Personal Care services, Petitioner's request for an additional 10 hours per week of Personal Care services would duplicate another type of LTC service authorized. Specifically, with the approval of the requested additional 57 hours per week of Personal Care services, Petitioner will be authorized to receive the following LTC services: 28 hours per week of Attendant Care services, 135 hours per week of Personal Care services (emphasis added), and 5 hours per week of Homemaker services. This equals 168 hours per week; there are 168 hours in one week. Thus, part of Petitioner's instant request would duplicate and/or overlap with another type of LTC service being provided. Although Petitioner established that despite all of the currently approved LTC services, Petitioner still has an unmet need for assistance with ADLs while residing in the community. However, the record indicates that the Petitioner requested more Personal Care services (in terms of quantity of hours per week) than is needed, and would not duplicate other services. Lastly, Petitioner provided insufficient evidence to establish that the approval of an additional 10 hours per week of Personal Care services would not duplicate other services as the approval of such would grant the Petitioner more than 24-hour care. Simply, Petitioner requested a quantity of Personal Care services that is larger than his weekly needs.

60. Accordingly, upon consideration of the parties' admitted evidence, the parties' sworn testimony, and the aforementioned applicable laws and policies, the undersigned concludes that Petitioner established that the requested additional 57 hours per week of Personal Care services, at issue, are medically necessary. The undersigned finds that Petitioner has established by a

preponderance of the evidence that Respondent's denial of an additional 57 hours per week of Personal Care services was incorrect. Subsequently, the undersigned concludes that Petitioner has not established that the requested additional 10 hours per week of Personal Care services, at issue, are medically necessary. The undersigned finds that Petitioner has not established by a preponderance of the evidence that Respondent's denial of an additional 10 hours per week of Personal Care services was incorrect.

DECISION

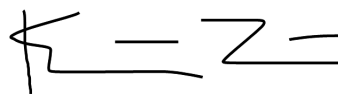
Petitioner's request for a Medicaid Fair Hearing did not comply with Fla. Admin. Code R. 59G-1.100(8)(e) regarding the plan appeal process with respect to Respondent's termination of ten (10) hours per week of Respite Care services. This issue in the case is **DISMISSED WITHOUT PREJUDICE** and is now closed.

Petitioner's request for a Medicaid Fair Hearing regarding Respondent's denial of eighty-four (84) hours per week of Personal Care services did not comply with Fla. Admin. Code R. 59G-1.100(18)(h). This issue in the case is **DISMISSED** and is now closed.

Respondent's denial of an additional fifty-seven (57) hours per week of Personal Care services is **REVERSED**. Petitioner's request for relief is hereby **GRANTED**.

Respondent's denial of an additional ten (10) hours per week of Personal Care services is **AFFIRMED**. Petitioner's request for relief is hereby **DENIED**.

DONE and ORDERED this 13th day of May, 2021, in Tallahassee, Leon County, Florida.



Digitally signed by Kristopher León
Reason: 21-FH[REDACTED]; 21-FH[REDACTED]
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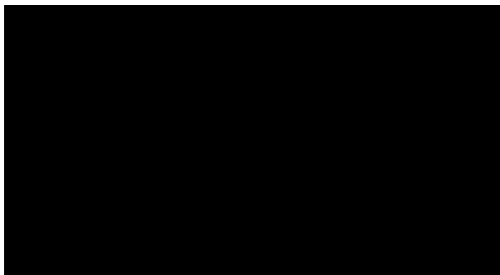
KRISTOPHER LEÓN, Hearing Officer

Agency for Health Care Administration
Office of Fair Hearings
[REDACTED] Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407
Office: (850) 412-3649
Fax: (850) 487-1423
Email: OfficeOfFairHearings@ahca.myflorida.com

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:



Paige S. Comparato
Counsel for Respondent
paige.comparato@hoganlovells.com

Craig H. Smith
Counsel for Respondent
craig.smith@hoganlovells.com

Sunshine Health
SunshineHealth_MFH@centene.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com.