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

FILED
May 09, 2023, 12:02 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER,

AHCA Case No.: 23-FH0222
Plan ID No.: [redacted]

vs.

SIMPLY HEALTH CARE PLANS. INC.,

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 23, 2023, at 2:30 p.m. Eastern Standard Time.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Sharon Nealy
Fair Hearing Coordinator
Simply Health Care Plans, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's personal care services (from forty-two hours (42) hours per week to thirty-seven (37) hours per week) was correct.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative and [redacted] appeared on behalf of the Petitioner.

Sharon Nealy, Fair Hearing Coordinator, for Simply Health Care Plans, Inc. ("Simply") appeared on behalf of Respondent. Dr. Marc Kaprow ("Dr. Kaprow"), Medical Director for Simply, attended as a witness for Respondent. Taiya Keller, State Fair Hearings Nurse attended as witness but did not testify.

Stephanie Lang, Program Operations Administrator for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as an observer.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner an eighty-seven (87)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "FL Simply SFH Evidence Packet [Petitioner].pdf." Absent an objection from the Petitioner undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply. Simply is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. As of the date of the hearing, Petitioner is [redacted]. *See* Respondent's Composite Exhibit 1 at page 8. Petitioner lives in a [redacted] *Id.* at 7-8.

3. As reported on the Florida Department of Elder Affairs: 701B Comprehensive Assessment ("701B Assessment") dated March 28, 2023, Petitioner has the following health conditions:

. *Id*. at 14-15. Petitioner receives the following specialty care: and daily. *Id*. at 15. Petitioner needs supervision because is . *Id.* at 17.

4. With regard to activities of daily living ("ADLs"), Petitioner needs total assistance (cannot do at all) with . *Id.* at 12. With regard to instrumental activities of daily living ("IADLs"), Petitioner needs total assistance with .

Id. at 13.

5. On August 12, 2022, Respondent issued a Notice of Adverse Benefit Determination ("NABD") reducing Petitioner's personal care services. The NABD states, in pertinent part:

> We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: *(See Rule)*
> . . .
> - Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
>   1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>   2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
>   3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;
>
> and one of the following:
>
> 1. Enable the enrollee to maintain or regain functional capacity; or

2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

. . .

The facts that we used to make our decision are: You asked to reduce T1019CG - PC from 42 HRS/WEEK to 37 HRS/WEEK.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

Id. at 37-38.

6. On October 28, 2022, Petitioner requested a plan appeal. *Id.* at 56. On November 16, 2023, Petitioner issued a Notice of Plan Appeal Resolution ("NPAR") denying Petitioner's plan appeal. The NPAR states as follows, in pertinent part:

> On 10/28/2022 we received your timely plan appeal request regarding Simply Healthcare Plans, Inc.'s Notice of Adverse Benefit Determination dated 08/22/2022, NABD Number 112612425, REDUCING the T1019CG - PC - 42 HRS / WEEK provided to [Petitioner]. The facts that we used to make our decision are: You asked to reduce T1019CG - PC from 42 HRS/WEEK to 37 HRS/WEEK.
>
> On 11/15/2022, after consideration of the information you provided to Simply in support of your plan appeal, Simply hereby DENIES your plan appeal. We read your appeal for services (T1019 = Personal care & A5130 Homemaker = unskilled care; dates of service 08/26/2022 and forward). We have denied this on appeal. Your doctor wants you to have special care (S5125 = Attendant care (skilled care). You want a different kind of care (unskilled care). Your doctor feels there is a medical need for more care. Your doctor wants you to have around the clock (skilled) care. We do not see that you have gotten better since your doctor asked for around the clock (skilled) care. We cannot give less care than your doctor has ordered. This is why we cannot approve those services (unskilled care). We based this decision on the Florida Medicaid Statewide Managed Care Long Term Care Program Coverage Policy. Your case was looked at by a board certified in Internal Medicine medical director for Simply.

Id. at 59.

7. On January 30, 2023, Petitioner requested a Fair Hearing regarding the reduction of PDO personal care services (AHCA Case No. 23-FH0222) and the subsequent termination of PDO

personal care services (AHCA Case No. 23-FH0220) and homemaker services (AHCA Case No. 23-FH0223). On March 2, 2023, the undersigned dismissed AHCA Case No. 23-FH0220 and AHCA Case No. 23-FH0223 for failure to comply with Rule 59G-1.100(8)(e), Florida Administrative Code, requiring an Enrollee to initiate and complete a plan appeal before making a Fair Hearing request. On March 6, 2023, the undersigned issued an Order Scheduling Fair Hearing By Telephone and Prehearing Instructions in the instant case setting the Fair Hearing for March 23, 2023 at 2:30 p.m. and all parties were notified.

8. Dr. Kaprow testified that prior to the NABD issued on August 12, 2022, *supra* ¶5, Petitioner was approved for sixty-five (65) hours per week of personal care services (consisting of twenty-eight (28) hours per week of traditional personal care services and thirty-seven (37) hours per week of PDO personal care services) and six (6) hours per week of homemaker services. *Id*. at 43.

9. Dr. Kaprow testified that as of August 16, 2023, Petitioner's medical condition changed. As a result, [redacted] physician ordered (and Simply authorized) one hundred and sixty-eight (168) hours per week, or "round-the-clock," skilled attendant nursing care. *Id*. at 43, 50. Dr. Kaprow explained that Simply denied the plan appeal in this case and terminated Petitioner's unskilled personal care and homemaker services in AHCA Case No. 23-FH0220 and 22-FH0223, because skilled attendant care service providers can provide all the unskilled services that are needed. *Id* at 50, 81-83. Dr. Kaprow testified that the services at issue in this case (unskilled personal care services) were reduced and, ultimately, terminated because they were duplicative of the "round-the-clock" skilled nursing care services Petitioner received.

10. asserted that, at the start of this case, the intent was for some of Petitioner's previously approved homemaker service hours to be converted to PDO personal care services and that Petitioner's thirty-seven (37) hours per week of PDO personal care services were supposed to be increased to forty (40) hours per week. testified that should receive back pay for the PDO personal care services continued to provide since the reduction at issue in this case. did not present any evidence to show that the PDO personal care services at issue are medically necessary or that they are not duplicative of skilled attendant care services. also did not quantify the number of PDO personal care hours should be paid for or submit any evidence as to the total payment she should receive.

CONCLUSIONS OF LAW

11. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

13. Because Respondent is reducing a previously approved service, Respondent bears the burden of proof with regard to the reduction of PDO personal care services. With regard to Petitioner's request for corrective action (back pay), the burden of proof is on Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

14. The Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to personal care services:

> **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.
> . . .
> **1.3.1 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
>
> . . .
> **1.3.9 Instrumental Activities of Daily Living (IADLs)**
> When necessary for the recipient to function independently, including:
> - Grocery shopping
> - Laundry
> - Light housework
> - Meal preparation
> - Money Management
> - Personal hygiene
> - Transportation
> - Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)
>
> . . .
> **4.1 General Criteria**
> Florida Medicaid LTC plans cover services that meet all of the following:
> - Are determined medically necessary, as defined in this rule
> - Do not duplicate another service
> - Meet the criteria as specified in this policy
>
> . . .

4.2.2.6 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.

LTC Policy at pages 1-4.

15. The LTC Policy also addresses medical necessity:

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.

LTC Policy at pages 2-3.

16. The Florida Medicaid Definitions Policy (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

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 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.

Definitions Policy at page 7.

17. With regard to corrective action, Rule 59G-1.100(3)(g), Florida Administrative Code, gives the Office of Fair Hearings jurisdiction when a recipient "makes a hearing request regarding a denial or reduction to a medically necessary Florida Medicaid services and seeks corrective action." Rule 59G-1.100(17)(p), Florida Administrative Code, states that if "the fair hearing involves corrective action, the recipient must demand the corrective action and submit record evidence of the recipient's liability or potential liability for payment of the already-provided service." Rule 59G-1.100(18)(f), Florida Administrative Code, states that "[t]he Final Order may prescribe corrective action retroactively to the date the incorrect action was taken."

18. The record reflects that in a Respondent initially reduced Petitioner's PDO personal care services from forty-two (42) to thirty-seven (37) hours per week in a NABD dated August 12, 2022. *See* supra ¶ 5. Subsequently, Petitioner was approved for one hundred and sixty eight (168) hours per week, or "round-the clock," skilled attendant care services. *See* supra ¶ 6. On October

28, 2022, Petitioner requested a plan appeal regarding the reduction of PDO personal care services. Respondent denied the plan appeal as duplicative of the "round-the clock" skilled attendant care services in place. *See* supra ¶ 6. In related cases (AHCA Case Nos. 23-FH0220 and 23-FH0223), Respondent terminated all of Petitioner's unskilled services (including the PDO personal care services at issue in this case) as duplicative of Petitioner's "round-the-clock" skilled attendant care services. *See* supra ¶ 6.

19. Section 4.1 of the LTC Policy states that Florida Medicaid LTC plans cover services that meet all of the following conditions: are determined medically necessary, as defined in this rule; do duplicate another service; and must meet the criteria as specified in this policy. *See* supra ¶ 14.

20. Dr. Kaprow provided credible and persuasive testimony that the PDO personal care services at issue in this case are duplicative of the one hundred and sixty-eight hours (168) per week, or "round-the-clock," attendant skilled nursing care Petitioner was authorized to receive. As Dr. Kaprow testified, unskilled services (such as personal care services) may be provided by a skilled nurse. *Id*. at 80-83. Therefore, the PDO personal care services at issue do not meet Section 4.1 of the LTC Policy because they are duplicative of the attendant skilled nursing care services. Although [redacted] asserted that [redacted] should receive back pay for PDO personal care services, [redacted] did not present any evidence to refute Respondent's determination that the PDO personal care services at issue are duplicative of the skilled attendant care services. [redacted] [redacted] also did not quantify or submit any evidence of the total amount that [redacted] would be owed by Simply.

21. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that the services at issue do not meet LTC Policy criteria. Therefore, the Respondent proved that its decision in this matter was correct. With regard to Petitioner's request for corrective action (back pay), the undersigned finds that Petitioner did not show by a preponderance of the evidence that corrective action is warranted.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent's reduction of personal care services is **AFFIRMED.** Petitioner's appeal is **DENIED.**

Petitioner's request for corrective action (back pay) is **DENIED.**

DONE AND ORDERED this 9th day of May 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher
23-FH0222
2023.05.09
10:58:27 -04'00'

_____

LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop #11
Tallahassee, FL 32308-5407

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:

[redacted]

Simply
MedicaidFairHearings@simplyhealthcareplans.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com