

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



FILED

Jun 30, 2023, 3:04 pm
OFFICE OF FAIR HEARINGS

[REDACTED]
PETITIONER,

AHCA Case No.: 23-FH0719
[REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on May 17, 2023, at 9:00 a.m., Eastern Standard Time (EST).

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's Authorized Representative

For the Respondent:

Christian Pacheco
Senior Director of Quality Improvement,
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that the respondent's reduction of Petitioner's personal care services was correct.

PRELIMINARY STATEMENT

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

Christian Pacheco, Senior Director of Quality Improvement for Sunshine State Health Plan, Inc. (“Sunshine Health”) appeared on behalf of Respondent. Dr. John Carter (“Dr. Carter”), Medical Director of Long Term Care (“LTC”) for Sunshine Health, provided testimony on behalf of Respondent. The following persons attended as observers: Katie Maldonado, Utilization Management for Sunshine Health; Amber McNeill, Care Coordinator for Sunshine Health; Dr. Jessica Hall, Case Manager Supervisor for Sunshine Health; and Sandra Durden, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one-hundred and forty-nine (149)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as file title “MFH packet [Petitioner’s surname].pdf”. Absent an objection from the Petitioner, the undersigned admitted the one-hundred and forty-nine (149)-page packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

Petitioner did not introduce any exhibits at the Fair Hearing.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine Health. See page 32 of RCE 1. Sunshine Health is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is [REDACTED]. *Id.* Petitioner lives with [REDACTED]. *Id.*

3. Petitioner is diagnosed with the following: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 78.

4. As provided in the Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated April 5, 2023, (“701B”), Petitioner’s needs for activities of daily living (“ADLs”) are as follows: [REDACTED] Petitioner needs assistance (but not total help); for [REDACTED] Petitioner needs supervision or prompt; and for [REDACTED] Petitioner uses assistive devices. *Id.* at 73. Petitioner always has assistance with [REDACTED] ADLs. *Id.*

5. As provided in the 701B, Petitioner’s needs for instrumental activities of daily living (“IADLs”) are as follows: [REDACTED] [REDACTED] Petitioner needs total assistance (cannot do at all); and for [REDACTED], Petitioner needs supervision or prompt. *Id.* at 74. Petitioner always has assistance with [REDACTED] IADLs. *Id.*

6. Respondent reduced Petitioner’s personal care services by five (5) hours, from thirty-five (35) hours to thirty (30) hours per week. Petitioner’s request to reinstate the five (5) personal care hours per week was denied in a Notice of Adverse Benefit Determination (“NABD”), dated March 16, 2023. The NABD explained the basis of the denial as follows:

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: Sunshine Health has looked at the member's present care needs and provided home services. The member's present care plan includes 35 hours per week of Personal Care Services. Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will reduce the Personal Care Services from 35 hours per week to 30 hours per week. Per assessment, the member is independent with eating and mobile, does not require supervision, and lives with [REDACTED] who is an informal support and per policy the current hours are adequate to meet member’s needs. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

....

Pages 4 – 5 of RCE 1.

7. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated April 1, 2023, upholding the reduction. *Id.* at 94 - 97. The NPAR explained as follows:

The reason for our decision was based on the assessment of the members care needs and household and caregiver status, the reduction of Personal Care Services from 35 hours/week to 30 hours/week 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 Medical Director who is a Board Certified Physician in Internal Medicine.

Page 94 of RCE 1.

8. On April 3, 2023, Petitioner requested Fair Hearings to challenge the reduction of personal care services. On April 26, 2023, the undersigned issued an Order Consolidating and Scheduling Fair Hearings by Telephone and Prehearing Instructions, setting the hearing for May 17, 2023, at 9:00 a.m. EST.

9. Dr. John Carter is a LTC Medical Director for Sunshine Health. Dr. Carter's testimony established that thirty-five (35) hours of personal care services weekly for Petitioner is not medically necessary because Petitioner is alert and oriented, and [REDACTED] is able to express [REDACTED] wants and needs. Dr. Carter testified that based on the 701B assessment and LTC plan of care, Petitioner needs assistance with most of [REDACTED] ADLs, but [REDACTED] is able to feed [REDACTED] transfer with minimal assistance, can ambulate with a walker for short distances, and needs [REDACTED]

[REDACTED]. Dr. Carter further testified that Petitioner lives with [REDACTED], including [REDACTED] direct service worker ("DSW") under the Participant Direction Option option ("PDO"). [REDACTED] does not work outside of the house, and [REDACTED] assists with Petitioner's support. Dr. Carter testified that after a careful review and assessment of Petitioner's needs, it was decided that thirty (30) hours of personal care services per week is adequate to meet Petitioner's care needs. Dr. Carter contends that although there have been no changes to the Petitioners' care needs since the last LTC Plan developed on May 24, 2023, *id.* at 32 – 34, the thirty-five (35) hours of weekly personal care services approved for Petitioner were excessive, in retrospect. Dr. Carter pointed to the

purpose for Petitioner care services, that are determined by the LTC (Long Term Care) Ancillary Service Criteria, which has the goal of providing “supportive services in the home to address the member’s cognitive and functional deficits, which may be a result of their medical conditions. The services will assist in maintaining the members in their home and community environment, in a safe manner, to avoid the risk for nursing home placement.” *Id.* at 123. Dr. Carter explained that the LTC Ancillary Service Criteria provides for the on-going assessment of members. *Id.* at 126. Dr. Carter further explained that the determination for services is dependent on the level of support for cognitive functional needs. *Id.* at 128. In this case, Petitioner’s ADLs were measured at a moderate functional impairment level, and it was taken into consideration that ■ lives with ■ family who provide natural supports with both ■ ADLs and IADLs. Dr. Carter concluded that these factors were reviewed and considered, resulting in the determination that thirty-five (35) hours of weekly personal services were excessive for Petitioner. Dr. Carter testified that ■ upholds the determination that thirty (30) hours of personal care combined with five (5) hours of homemaker care services each week, together with the natural supports of ■ family, adequately meet Petitioner’s medical care needs.

10. Petitioner’s ■ and primary caregiver, ■, testified that there have been no changes to Petitioner’s condition. ■ testified that there has been no real reason stated why the Respondent is reducing Petitioner’s weekly personal care hours, and that, in fact, the assessor who filled out the 701B did not visit Petitioner in person, face-to-face, to properly assess ■ needs. ■ further testified that Respondent did not refer any physicians to visit Petitioner in person, nor were any of Petitioner’s physician providers contacted to give information on Petitioner’s current health condition. ■ explained that ■ is

Petitioner's DSW, and that is the only source of [REDACTED] income because [REDACTED] is unable to work while taking care of Petitioner in their home. [REDACTED] testified that Petitioner's mental health is deteriorating and, consequently, [REDACTED] needs more personal care hours, not less.

11. Dr. Carter provided rebuttal testimony that [REDACTED] was present on the telephone when the assessor called for the 701B assessment in February of 2023. Dr. Carter referred to the 701B that included the assessor's notes that she, as care coordinator, "attempted to complete face to face visit in member's home. Due to COVID-19 member and [REDACTED] choose for a telephone assessment in lieu of face to face visit." *Id.* at 70.

12. In making is decision in this case, Respondent relied upon the Sunshine Health Policy and Procedure LT.UM.09, which states in pertinent part, as follows:

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:

- Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- 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
- 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
- Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

...

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

Id. at 138.

CONCLUSIONS OF LAW

13. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2)(2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

15. Because Respondent is reducing current services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

16. The 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

...

1.3.5 701-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
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.16 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 LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service
- Meet the criteria as specified in this policy

...

4.2 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee’s authorized plan of care

- Provided in accordance with a goal in the enrollee’s plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

...

6.0 Documentation

...

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

LTC Policy at pages 1-8.

17. 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.

18. The Florida Medicaid Definitions Policy, 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.

19. Respondent reduced Petitioner’s thirty-five (35) hours of weekly personal care services to thirty (30) hours weekly. See supra ¶ 6. In the NABD, dated March 16, 2023, Respondent denied Petitioner’s request to reinstate the total thirty-five (35) hours, as upheld in the NPAR, dated April 1, 2023. See supra ¶¶ 6, 7. Respondent explained that Petitioner’s request was not

medically necessary based on the plan's review criteria and guidelines but did not specify which of the five medical necessity criteria Petitioner's request failed to meet. See supra ¶ 6.

20. As provided in the LTC Policy, personal care is 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 evidence presented in this case supports Respondent's reduction of personal care services. As provided in the 701B, Petitioner's needs for activities of daily living ("ADLs") are as follows: [REDACTED], Petitioner needs assistance (but not total help); [REDACTED], Petitioner uses assistive devices. See supra ¶ 4. Petitioner always has assistance with [REDACTED] ADLs. *Id.*

21. As provided in the 701B, Petitioner's needs for instrumental activities of daily living ("IADLs") are as follows: [REDACTED], Petitioner needs total assistance (cannot do at all); and for [REDACTED], Petitioner needs supervision or prompt. See supra ¶ 5. Petitioner always has assistance with [REDACTED] IADLs. See supra ¶ 5 /

22. With regard to living arrangements, Petitioner resides in the home with [REDACTED]. See supra ¶ 2. Petitioner's [REDACTED] DSW and [REDACTED] does not work outside of the house. Petitioner's [REDACTED] provides natural support for Petitioner's needs. See supra ¶ 2. Petitioner needs supervision due to physical limitations and [REDACTED] cognitive impairment. See supra ¶ 2. As Dr. Carter testified, Petitioner suffers from moderate functional impairment. See supra ¶ 9. Petitioner is [REDACTED] but does not get lost or wander. See supra ¶ 2.

23. As Respondent bears the burden of proof, Respondent must show that the reduction of personal care services was correct. Here, the Petitioner receives thirty (30) hours of personal care services per week from [REDACTED], to partially assist with [REDACTED] ADL's.

24. Based on the foregoing, the record shows that the current level of personal care services are not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment," and are "in excess of [Petitioner's] needs." See supra ¶ 16. Accordingly, the record shows that the reduction of the personal care services to thirty (30) hours per week are adequate to meet Petitioner's medically necessary care. Therefore, the current level of personal care services are not medically necessary.

25. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent has proven by a preponderance of the evidence that Respondent's reduction of Petitioner's personal care services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 30th day of June, 2023, in Tallahassee, Leon County, Florida.



Debbie K. Winicki
23-FH0719
2023.06.30 10:43:14
-04'00'

DEBBIE WINICKI, 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]
[REDACTED]
[REDACTED]

Sunshine State Health Plan, Inc.
SunshineHealth_MFH@centene.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com