



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

FILED

Sep 03, 2020, 8:20 am
OFFICE OF FAIR HEARINGS

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PETITIONER,

AHCA Case No.: 20-FH █

Plan ID No.: █

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

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PETITIONER,

AHCA Case No.: 20-FH █

Plan ID No.: █

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_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on August 5, 2020, at █

APPEARANCES

For the Petitioner: ■
Petitioner

For the Respondent: Maria Mojica
Compliance Specialist
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional 1 hour per week of homemaker services was incorrect.

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent’s denial of an additional 9 hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner appeared at the hearing and provided testimony on his own behalf.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. (“Sunshine”), appeared for the hearing and represented Respondent. Dr. John Carter (“Dr. Carter”), Long Term Care (“LTC”) Medical Director for Sunshine, provided testimony on behalf of the Respondent. The following individuals also appeared on behalf of Respondent but did not provide testimony: Larry Reid, Case Coordinator for Sunshine; Gregory Felix, LTC Care Coordinator for Sunshine; Teresa Barran-Gornto, Supervisor of LTC for Sunshine; and Louise Jeanty, Supervisor of Quality Improvement for Sunshine.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Interpreter Randolph, translator number 333729, appeared for the hearing and provided creole translation services for Petitioner.

Prior to the hearing, Petitioner did not send to the Office of Fair Hearings and Respondent an evidence packet. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 100-page evidence packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; a Medicaid Fair Hearing Summary, dated May 11, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated March 9, 2020; Sunshine’s care plan, signed by the Care Manager on March 4, 2020; the care plan, signed by the Care Manager on May 8, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of March 2, 2020 (the “3/2/20 701B”); Sunshine’s Expedited Appeal Request Decision, dated March 13, 2020; Sunshine’s Standard Appeal Acknowledgment, dated March 13, 2020; the Notice of Plan Appeal Resolution (“NPAR”), dated April 13, 2020; the Sunshine Health Policy and Procedure LT.UM.09; and Fla. Admin. Code R. 59G-1.010. Absent an objection from Petitioner, the undersigned admitted Respondent’s 100-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s LTC plan. *See* Respondent’s Composite Exhibit 1, page 2. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is an adult male who lives alone in a private residence, and has no local family members. *See* Respondent’s Composite Exhibit 1, pages 23 and 31 – 32. Petitioner has the following health conditions: acid reflux/gastrointestinal reflux disease (“GERD”); arthritis; high

blood pressure; high cholesterol; non-insulin dependent diabetes mellitus; heart problems; kidney problems; osteoporosis; stroke/cerebrovascular accident (“CVA”); and anxiety. See Respondent’s Composite Exhibit 1, pages 37 – 38.

3. The 701B reflects the following regarding Petitioner’s Activities of Daily Living (“ADLs”). Petitioner needs no assistance with eating. See Respondent’s Composite Exhibit 1, page 35. Petitioner uses assistive devices for using the bathroom, transferring and walking/mobility. *Id.* Petitioner needs assistance (but not total help) with bathing and dressing. *Id.* The 701B also reflects the following:

Member stated that he had a 2 strokes in the past and as a result he has pain in his right leg. He also reported being shot while serving as [REDACTED] which is the reason he became disabled. He reports having pain management injection once a month. Member also reported that he had right shoulder surgery which it makes difficult to lift his right arm. However, he is still able to wash UE such as chest, face and neck. Member is also able to wash private area. Member reported being continent of b/b and able to toilet self. Member still needs assist of 1 with shower, assist in getting in/out of tub due to fear to fall. Member was observed ambulating very slowly. CC noticed left leg was dragging which the member reported that he got shot on the left ankle. Member uses the walker for long distance and outside. Member uses the cane for very short distance in his apartment. Apartment is very small.

Respondent’s Composite Exhibit 1, page 35.

4. Regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the 701B reflects that Petitioner needs no assistance with using the telephone, managing medication, and managing money. See Respondent’s Composite Exhibit 1, page 36. Petitioner needs assistance (but not total help) with preparing meals and using transportation. *Id.* Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, and shopping. *Id.* Further, the 701B reflects the following:

Member require total care with homemaking, cleaning, laundry and shopping which the member reported that the aide provides. Member is able to manage his own financial affairs, medication management. Member reported having a car although he stated that he does not use his vehicle much and uses public transportation. Member needs assist in getting in/out of vehicle. Member is receiving 7hrs per week of homemaking which covers the laundry. Member has washer/dryer in his apartment.

Respondent's Composite Exhibit 1, page 36.

5. Petitioner is currently authorized to receive the following home and community-based services: 12 hours weekly of personal care services; 7 home delivered meals weekly; and 6 hours per week of homemaker services. See Respondent's Composite Exhibit 1, page 29.

6. On March 9, 2020, Respondent issued an NABD denying Petitioner's request for an additional 1 hour per week of homemaker services and an additional 9 hours per week of personal care services. See Respondent's Composite Exhibit 1, pages 4 – 8. The NABD stated the reason for Respondent's determination as follows:

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: (See Rule)

...

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or

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

...

The facts that we used to make our decision are:

The request for an extra 9 hours/week of Personal Care Services + an extra 1 hour/week of Homemaker Services is denied. Based on the assessment, the members currently approved services are adequate to meet the member's care needs. The member's present care plan includes 12 hours/week of Personal Care Services + 6 hours/week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Respondent's Composite Exhibit 1, pages 4 – 5.

7. Petitioner requested an expedited appeal of Respondent's denial of Petitioner's request for an additional 1 hour per week of homemaker services and an additional 9 hours per week of personal care services. See Respondent's Composite Exhibit 1, page 50. Petitioner's expedited appeal request was denied. *Id.* On April 13, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 62. The NPAR stated as follows:

On March 13, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated March 9, 2020, Notice of Adverse Benefit Determination Number [REDACTED], denying an additional 9 hours per week of personal care (the person who helps bathe and dress you) and an additional 1 hour a week of homemaker service (the person who cleans for you), provided to [Petitioner].

On April 10, 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 an additional 9 hours per week of personal care (the person who helps bathe and dress you) and an additional 1 hour a week of homemaker service (the person who cleans for you), effective April 9, 2020.

The reason for our decision was: The appeal for an extra 9 hours/week of Personal Care Services + an extra 1 hour/week of Homemaker Services is denied and the original denial is denied. Based on further assessment, **your currently approved services are adequate to meet your care needs.** Your current care plan includes 12 hours/week of Personal Care Services + 6 hours/week of Homemaker Services. 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 Board Certified Physician in Family Medicine.

Respondent's Composite Exhibit 1, page 62. (Emphasis added.)

8. Petitioner requested a Fair Hearing due to the denial of an additional 1 hour per week of homemaker services and the denial of an additional 9 hours per week of personal care services.
9. During the Fair Hearing, Petitioner testified that he needs assistance with shopping, cleaning, laundry, preparing food, and bathing.
10. Dr. Carter is the Long-Term Care Medical Director for Sunshine. Dr. Carter explained that Petitioner's present services are enough to take care of his needs.

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 Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).
12. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).
13. The burden of proof in this proceeding is governed by Fla. Admin Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

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

15. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”) SMMC LTC Policy. The Agency’s SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC LTC Policy provides as follows:

1.1 Description and Program Goal

Under the Statewide Medicaid Managed Care Long-term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. The

assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.
- (b) All other LTC supportive services must meet all of the following:
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

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

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.1 Home and Community-Based Supportive Services

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

4.2.1.1 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.

...

4.2.1.8 Home Delivered Meals

The provision of nutritionally sound meals delivered to an enrollee's home when an enrollee has difficulty shopping for, or preparing food, without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake. The meals must meet the current Dietary Guidelines for Americans, the United States Department of Agriculture My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained

homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

...

4.2.1.15 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:

...

4.2.2.6 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.

SMMC LTC Policy, pages 1-8.

16. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medical necessity" as follows:

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. In the instant case, Respondent denied Petitioner's request for an additional 1 hour of homemaker services per week, and an additional 9 hours per week of personal care services. See supra ¶ 6 and 7. As established on the record by the evidence and testimony, Respondent denied Petitioner's request for an additional 1 hour of homemaker services per week and additional 9 hours of personal care services per week, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. See supra ¶ 6 and 7.

18. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. See supra ¶ 15. Section 4.2.1.1 of the SMMC LTC Policy reflects that adult companion care services are "[t]he 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." See supra ¶ 15. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are [t]o provide assistance with ADLs

and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” See supra ¶ 15.

19. The evidence presented in this case does not reflect that Petitioner is in need of an additional 1 hour per week of homemaker services and 9 additional hours per week of personal care services. Specifically, regarding ADLs, Petitioner needs no assistance with eating, and he uses assistive devices for using the bathroom, transferring and walking/mobility. See supra ¶ 3. Petitioner needs assistance (but not total help) with bathing and dressing. *Id.* Regarding IADLs, Petitioner needs: assistance (but not total help) with preparing meals and using transportation; and total assistance (cannot do at all) with heavy chores, light housekeeping, and shopping. See supra ¶ 4. Petitioner needs no assistance with using the telephone, managing medication, and managing money. *Id.* Petitioner lives alone in a private residence, and has no local family members. See supra ¶ 2. However, Petitioner is ambulatory, and can wash his chest, face, neck and private area. Petitioner is continent of bowel and bladder, and “able to toilet self.” See supra ¶ 3. Dr. Carter explained that Petitioner’s present services are enough to take care of his needs. See supra ¶ 10. Although Petitioner contends that he needs assistance with shopping, cleaning, laundry, preparing food, and bathing, *supra* ¶ 9, Petitioner offered no substantive testimony on how the denial of the additional adult companion care services and additional personal care services will impact his ability to manage his ADLs and IADLs. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for *each* ADL and IADL) to justify the approval of the 1 additional hour of adult companion care services weekly and 9 additional hours of personal care services weekly. Based

upon the evidence presented by both parties, Petitioner failed to establish that the requested adult companion care services and personal care services are warranted in this case.

20. Section 1.3.14 of the SMMC LTC Policy requires that the requested services must “[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See *supra* ¶ 15. Petitioner is currently authorized to receive the following home and community-based services: 12 hours weekly of personal care services; 7 home delivered meals weekly; and 6 hours per week of homemaker services. See *supra* ¶ 5. The NPAR explains that Petitioner’s “currently approved services are adequate” to meet Petitioner’s care needs. See *supra* ¶ 7. Considering the SMMC LTC Policy’s definitions for adult companion care services, homemaking services, home delivered meals, and personal care services, *supra* ¶ 15, Petitioner did not demonstrate that his aforementioned needs, *supra* ¶ 20, are not sufficiently met by his currently authorized services. Further, given that Petitioner failed to establish that the requested homemaker services and personal care services are warranted in this matter, *supra* ¶ 20, the requested adult homemaker and personal care services are “in excess of [Petitioner’s] needs.” See *supra* ¶ 15.

21. In light of the both parties’ testimony and evidence, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving that the additional 1 hour per week of homemaker services and the additional 9 hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested additional homemaker services and personal care services was incorrect.


DECISION

Respondent's denial of an additional 1 hour per week of homemaker services is **AFFIRMED.**

Respondent's denial of an additional 9 hours per week of personal care services is **AFFIRMED.**

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

DONE AND ORDERED this 3rd day of September, 2020, in Tallahassee, Leon County, Florida.


Tracie Hardin
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20-FH [REDACTED]
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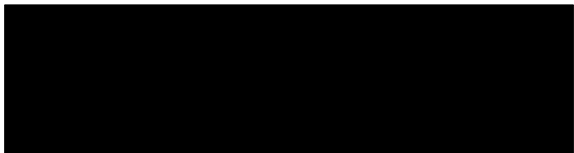
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:

[REDACTED]



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