



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

FILED

Jul 14, 2020, 9:04 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 8, 2020, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner Authorized Representative

For the Respondent:

Maria Mojica
Compliance Specialist
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for ten (10) hours per week of respite care services was incorrect.

PRELIMINARY STATEMENT

PRR0000110

All parties appeared telephonically. Petitioner's Authorized Representative and husband, [REDACTED], (" [REDACTED] ") appeared on behalf of the Petitioner.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine") appeared on behalf of Respondent. Melissa Layne, Senior Manager for Quality Improvement for Sunshine, Alicia Williams, Case Manager Supervisor for Sunshine, Suzanne Arzuaga, Care Coordinator for Sunshine, Stephanie Gunning, Case Management Supervisor for Sunshine, Lakisha Hughes Care Coordinator Supervisor for Sunshine, Desiree Harrell Care Coordinator for Sunshine, and Dr. John Carter ("Dr. Carter"), Long Term Care Medical Director for Sunshine, attended as witnesses for Respondent.

Lisa Sanchez, Medical Healthcare Program Analyst for the Agency for Health Care Administration ("Agency"), 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 a 100-page evidence packet. The evidence packet included: a Medicaid Fair Hearing Summary, dated May 21, 2020; A Notice of Adverse Benefit Determination ("NABD"), dated March 11, 2020; a Previous Plan of Care, signed March 4, 2020; a Current Plan of Care, signed May 14, 2020; a 701B Assessment, dated March 4, 2020; Petitioner's Plan Appeal Request, dated March 16, 2020; a Plan Appeal Acknowledgment, dated March 25, 2020; a Notice of Plan Appeal Resolution ("NPAR"), dated April 18, 2020; LT.UM.09 Long Term Care Criteria; and Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.010(166). Absent an objection from the Petitioner undersigned admitted the page packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. Respondent's Composite Exhibit 1 at 2.

2. As of the date of the Fair Hearing, Petitioner is 59-years old. Petitioner suffers from osteoarthritis, right side hemiplegia, incontinence, and has a history of stroke and seizures. *Id.* at 32 and 38 through 39. Petitioner lives with her husband, who provides care for Petitioner as Petitioner's primary natural support during the week. Petitioner's husband is disabled and does not work outside of the home. Petitioner's daughter assists with Petitioner's care on the weekends. Petitioner currently receives twenty-five (25) hours per week of personal care services and five (5) hours per week of homemaker services. *Id.* at 62. Petitioner requires total assistance with bathing, dressing, toileting and transferring. Petitioner utilizes an electric scooter and wheelchair to ambulate. *Id.* at 36.

3. Petitioner requested thirteen (13) hours per week of personal care services and ten (10) hours per week of respite care services. *Id.* at 4 through 5. Prior to Petitioner's request, Petitioner was receiving twelve (12) hours of personal care services and no respite care services. *Id.* Petitioner's request was partially denied in the NABD dated March 11, 2020. 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: The request for extra services (an extra 13 hours/week of Personal Care Services and the addition of 10 hours/week of In- Home Respite Care Services) is partially approved. The member's present care plan includes 12 hours/week of Personal Care Services and 5 hours/week of Homemaker Services.

Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will approve an extra 9 hours/week of Personal Care Services (and will deny the remaining requested 4 hours/week of Personal Care Services), and will deny the 10 hours/week of in-home Respite Care Services. The updated care plan approved by Sunshine Health will include 21 hours/week of Personal Care Services and 5 hours/week of Homemaker Services.

Id.

4. Petitioner requested a plan appeal and received an NPAR dated April 18, 2020, partially upholding the denial. The NPAR explained as follows:

On April 15, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby partially your plan appeal. As a result, [REDACTED] will receive addition of 4 hours per week of Personal Care Services and will deny the remaining requested 10 hours per week of In Home Respite Care Services, effective April 15,2020

The reason for our decision was:

The appeal for an extra 4 hours per week of Personal Care Services and the addition of 10 hours per week of In Home Respite Care Services is partially approved. Sunshine Health will approve the addition of 4 hours per week of

Personal Care Services and will deny the remaining requested 10 hours per week of In Home Respite Care Services. The updated care plan approved by Sunshine Health will include 25 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. at 62.

5. During the hearing, [REDACTED] testified that he is not seeking respite care but is seeking additional personal care services for Petitioner.

6. Dr. Carter testified that Petitioner's needs for personal services are met through the provision of homemaker services and personal care services.

CONCLUSIONS OF LAW

7. 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) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

9. Because Petitioner is requesting a new service, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.)

10. The Florida Medicaid Statewide Medicaid Managed Care Long-Term Care Program 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 and companion 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

...

4.2.1.15 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.

11. 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.

12. 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

13. ██████████ testified that he is not seeking respite care services to relieve himself from caring for Petitioner but rather is requesting more hours of personal care for Petitioner. ██████████ further testified that his only relief from providing care for Petitioner occurs on the weekends when his and Petitioner's daughter visits to assist with Petitioner's care. *Supra* ¶ 2 and ¶ 5.

14. As provided in section 4.1 of the LTC policy, respite care services must be medically necessary. A component of medical necessity is that services must 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." Respite care services are medically necessary when a recipient's natural supports need to be relieved on a short-term basis due to a planned or emergency absence. As established by the record, Petitioner has extensive medical needs, but the record does not reflect that Petitioner's natural support, ██████████, is absent or anticipating an absence in acting as a natural support for Petitioner.

15. Dr. Carter provided testimony that Petitioner's needs are met through the personal care services and homemaker services provided to Petitioner. Neither the documentary evidence nor testimony show that Petitioner's natural supports are unavailable or are expected to be unavailable. Thus, Petitioner has not demonstrated need for respite care services as defined *supra* ¶ 10, making the requested respite care services in excess of Petitioner's needs. Thus, Petitioner did not demonstrate that ten (10) hours of respite care per week are medically necessary.

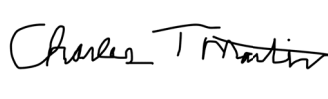

16. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Petitioner did not prove by a preponderance of

the evidence that Respondent's denial of ten (10) hours per week of respite care services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED:

Respondent's denial is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 14th day of July, 2020, in Tallahassee, Leon County, Florida.

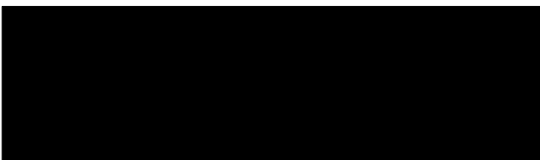
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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:





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