



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

FILED

Sep 28, 2020, 12:28 pm

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 [REDACTED] 2020, at [REDACTED]

APPEARANCES

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

For the Respondent: Kizzy Alleyne
Senior Paralegal
Sunshine State Health Plan, 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 was correct.

PRELIMINARY STATEMENT

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

Kizzy Alleyne, Senior Paralegal for Sunshine State Health Plan, Inc. (“Sunshine”) appeared on behalf of Respondent. The following attended as witnesses for Respondent: Dr. Leslie Smith (“Dr. Smith”), Medical Director for Sunshine; Alshanetha Williams, Case Manager Supervisor for Sunshine; Laticia Hughes, Supervisor for Sunshine; Arilu Diaz, Long Term Care Case Manager for Sunshine; and Louise Gentry, Supervisor of Quality Improvement for Sunshine.

Marielisa Amador, Medical/Health Care Program Analyst 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 a one hundred and two (102)-page evidence packet. The evidence packet included: a table of contents; a Medicaid Fair Hearing Summary; a Notice of Adverse Benefit Determination (“NABD”), dated June 26, 2020; a Long Term Care Person-Centered Care Plan (“POC”), dated June 19, 2020; a POC, dated July 10, 2020; a Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”), dated June 19, 2020; Expedited Appeal Acknowledgement, dated June 26, 2020; a Notice of Plan Expedited Appeal Resolution, dated June 28, 2020; a Revised Notice of Plan Expedited Appeal (“NPAR”), dated [REDACTED] 2020; Sunshine Health Policy and Procedure-LTC Ancillary Service Criteria-LT.UM.09 (“LT.UM.09”); and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010. Absent an objection from the Petitioner undersigned admitted the page packet into evidence as Respondent’s Composite Exhibit 1.

At the Fair Hearing, the record was held open, until August 12, 2020, at 5:00 p.m., to allow Petitioner to submit documents. The Respondent was allowed until August 19, 2020, at 5:00 p.m. to submit any comments or objections to those documents. Petitioner timely submitted ninety-

nine (99)-pages of documents. The documents included: a fax cover sheet, dated August 6, 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; PT Clinical Notes, dated [REDACTED] 2020; OT Clinical Notes, dated [REDACTED] 2020; a fax cover sheet, dated August 6, 2020; a letter from [REDACTED], dated [REDACTED] 2020; an e-mail from [REDACTED], dated August 6, 2020; Discharge Summary; [REDACTED] Discharge Summary for Admission Date: [REDACTED] 2020; [REDACTED] Discharge Summary for Admission Date: [REDACTED] 2019; fax cover sheet, dated December 10, 2019; Petitioner lab results, dated [REDACTED] 2019; Petitioner lab results, dated [REDACTED] 2019; a letter from [REDACTED] dated [REDACTED] 2020; Petitioner medical record, dated [REDACTED] 2019; Petitioner medical record, dated [REDACTED] 2020; Petitioner medical record, dated [REDACTED] 2020; Petitioner medical record, dated [REDACTED] 2020; a fax cover sheet, dated August 6, 2020; and a letter from [REDACTED], dated [REDACTED] 2020. Respondent did not submit a response or objection to Petitioner's documents. Absent an objection from Respondent, the undersigned hereby admits, Petitioner's ninety-nine (99)-page document, as Petitioner'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.
2. Petitioner is seventy-six (76)-years old. See page 31 of Petitioner's Composite Exhibit 1. Petitioner lives with her daughter, [REDACTED]. See page 36 of Respondent's Composite Exhibit 1. As testified to by [REDACTED], [REDACTED] has been Petitioner's caregiver for the past five

(5) years. As testified to by [REDACTED], [REDACTED] and the personal care aide are the only ones that provide care to Petitioner.

3. Petitioner is diagnosed with the following: dementia; edema; asthma; aphasia; chronic pain; type 2 diabetes; and multiple pressure ulcers. See page 31 of Petitioner's Composite Exhibit

1. Further, Petitioner suffers from incontinence, chronic urinary tract infections, and is wheelchair bound. *Id.* at 69. Petitioner "has physical limitations and needs hands on care and supervision." See page 40 of Respondent's Composite Exhibit 1. Petitioner requires two persons to transfer. *Id.* at 35.

4. Petitioner was formerly receiving care in an assisted living facility. *Id.* at 35. Petitioner was admitted to a hospital on [REDACTED] 2020, and was discharged on [REDACTED] 2020. *Id.* Petitioner was admitted to a rehabilitation facility, [REDACTED], upon discharge from the hospital. *Id.* Petitioner was admitted again to the hospital on [REDACTED] 2020, due to a blood clot. *Id.* Petitioner was discharged to her daughter's home on [REDACTED] 2020. *Id.* at 35 and 36.

5. In regards to her activities of daily living ("ADLs"), Petitioner needs assistance (but not total help) with bathing, dressing, using the bathroom, transferring, and walking/mobility. *Id.* at 35. Petitioner needs supervision or prompting with eating. *Id.* In regards to her instrumental activities of daily living ("IADLs"), Petitioner needs total assistance with heavy chores, light housekeeping, managing money, preparing meals, and shopping. *Id.* at 36. Petitioner needs assistance (but not total help) with using the telephone and managing medication. *Id.*

6. Petitioner's plan of care includes sixty (60) hours, weekly, of personal care services, for the period of June 13, 2020, through February 28, 2021. *Id.* at 29.

7. In the NABD, dated June 26, 2020, Respondent reduced Petitioner's personal care plan from sixty (60) hours to twenty (20) hours. *Id.* at 4 through 12. The NABD explained the basis of the reduction 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 an extra 54 hours per week of Personal Care Services is partially approved. The member's present care plan includes 60 hours per week of Personal Care Services through 6/30/2020, 6 hours per week of Personal Care Services resuming 07/01/2020. Based on the assessment of the member's care needs and household caregiver status, Sunshine Health will approve an extra 14 hours per week of Personal Care Services. The updated care plan approved by Sunshine Health will include 60 hours per week of Personal Care Services beginning 07/01/2020. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 4 through 5.

8. Petitioner requested a plan appeal and received an NPAR dated July 15, 2020, upholding the partial denial. *Id.* at 63 through 70.

9. As testified to by [REDACTED], [REDACTED] works forty (40) hours per week, Monday through Friday. As testified to by [REDACTED], [REDACTED] is currently working from home due to the COVID-19 pandemic, but is scheduled to return to her office in September 2020.

10. As testified to by [REDACTED], it takes the following amount of time to assist Petitioner with her ADLS: for bathing, (45) minutes to sixty (60) minutes; for dressing, fifteen (15) minutes; and for grooming, ten (10) minutes.

11. Dr. Smith is a Medical Director at Sunshine. Dr. Smith testified that her calculation “based on the member’s current needs allow for 19.5” hours of services for Petitioner, and that twenty (20) hours would serve Petitioner’s needs.

CONCLUSIONS OF LAW

12. 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).

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

14. Because Respondent is reducing a previously approved service, Respondent bears the burden of proof. 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 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.

16. 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.

17. 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.

18. LT.UM.09 provides as follows in regards to personal care services:

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 administer any medications, but may bring medications to the member and remind the member to take the medications 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:

- Activity of Daily Living (ADL) limitations
- Living situation
- Supervision needs
- Available Supports

...

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:
5. Services provided by Sunshine Health may not duplicate services that are provided under by another provider.
6. Escort services

...
Id. at 88 through 94.

19. The POC, dated July 10, 2020, provides that Petitioner receives sixty (60) hours per week of personal care services from June 13, 2020, through February 28, 2021. *See* page 29 of Respondent's Composite Exhibit 1. In the NABD, dated June 26, 2020, Respondent reduced Petitioner's personal care services from sixty (60) hours, weekly, to twenty (20) hours, weekly. *See* pages 4 through 12 of Respondent's Composite Exhibit 1. Although the NABD and NPAR presented the issue that an additional fifty-four (54) hours were requested, it does not appear that Petitioner ever received less than sixty (60) hours of personal care services from Sunshine. Moreover, Respondent provided multiple POCs and a 701B that show Petitioner was to receive 60 hours of personal care service, weekly, through February 28, 2021. *Id.* at 20, 25, and 36. Therefore, the issue is whether Respondent's reduction of Petitioner's personal care services was correct.

20. In the NABD, Respondent explained that the previously approved medical supplies were not medically necessary and that its decision was "[b]ased on the assessment of the member's care needs and household and caregiver status" *Id.* at 4 through 5. At the Fair Hearing, Dr. Smith testified, *supra* ¶ 11, that Petitioner needed only 19.5 hours of personal care services per week.

21. As provided in Respondent's policy, LT.UM.09, personal care services are to "provide assistance with eating, bathing, dressing, and personal hygiene, and other activities of daily

living.” Further, the policy provides that personal care provides with “preparation of meals” and “housekeeping tasks”. As discussed in LT.UM.09, personal care services are determined, in part, based on: the recipient’s ADL limitations; the recipient’s living situation; the recipient’s supervision needs; and the available supports. Moreover, 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.” As provided in the record, Petitioner requires assistance (but not total help) with all ADLs, except eating, and requires assistance (cannot do at all) with all IADLs, except for using the telephone and using transportation. *Id.* at 34 and 35. Here, Dr. Smith testified that Petitioner only requires approximately 19.5 hours of personal care service per week, but did not explain how she arrived at the figure. For example, Dr. Smith did not explain how much time each ADL should take accomplish based on Petitioner’s unique medical needs, nor did she explain how much assistance could be provided by Petitioner’s daughter.

22. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent did not prove by a preponderance of the evidence that Respondent’s termination of personal care was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent’s reduction of personal care services is **REVERSED**. Petitioner’s appeal based on Respondent’s reduction of is **GRANTED**.

DONE AND ORDERED this 28th day of September, 2020, in Tallahassee, Leon County, Florida.



Joseph Mabry

20-FH [REDACTED]

2020.09.28

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JOSEPH MABRY, Hearing Officer

Agency for Health Care Administration

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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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AHCA Medicaid Hearing Unit

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