



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

FILED

Sep 28, 2020, 3:34 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 September 9, 2020, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's 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 eight (8) hours of additional personal care services was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative and daughter,

[REDACTED] (" [REDACTED] ") appeared on behalf of the Petitioner.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. (“Sunshine”) appeared on behalf of Respondent. The following attended as witnesses for Respondent: Dr. John Carter (“Dr. Carter”), Long Term Care Medical Director for Sunshine; Leticia Hughes, Care Coordinator for Sunshine; Alshanetha Williams, Care Coordinator Supervisor for Sunshine; Wendy Mercado, Case Coordinator for Sunshine; and Melissa Layne, Senior Manager for Quality Improvement for Sunshine.

Stephanie Lang, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a thirty-four (34)-page evidence packet. The evidence packet included: an e-mail from [REDACTED], dated July 27, 2020; a second an e-mail from [REDACTED], dated July 27, 2020; an e-mail from [REDACTED], dated July 28, 2020; an e-mail from [REDACTED], dated July 31, 2020; an e-mail from [REDACTED], dated [REDACTED] 2020; a fax cover sheet, dated August 13, 2020, and two (2) pages of documents; an e-mail from [REDACTED], dated August 19, 2020; a fax cover sheet, dated August 13, 2020, and two (2) pages of documents; an e-mail from [REDACTED], dated August 24, 2020; a CT scan record, dated [REDACTED], 2020; Petitioner’s lab report, dated [REDACTED] 2020; Petitioner’s medical record, dated [REDACTED] 2020; Petitioner’s medical record, dated [REDACTED] 2020; an e-mail from [REDACTED], dated August 27, 2020; and a letter from [REDACTED], dated [REDACTED] 2020. Absent an objection from the Respondent, the undersigned admitted the thirty-four (34)-page packet into evidence as Petitioner’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-four (124)-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 15, 2020; a Plan of Care (“POC”), dated May 6, 2020; a POC, dated March 26, 2020; a Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”), dated May 1, 2020; a 701B, dated July 6, 2020; a fax cover sheet, dated June 23, 2020, with two (2) pages of documents; a fax cover sheet, dated June 8, 2020, with one document; an Expedited Appeal Acknowledgement, dated August 27, 2020; a Standard Appeal Acknowledgment, dated June 23, 2020; a Notice of Plan Expedited Appeal Resolution (“NPAR”), dated June 24, 2020; a Sunshine Health Policy and Procedure-LTC Ancillary Service Criteria-LT.UM.09; Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010; and a letter from Respondent, dated August 31, 2020. Absent an objection from the Petitioner, the undersigned admitted the one hundred and twenty-four (124)-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.
2. Petitioner is [REDACTED] years old. *See* page 31 of Respondent’s Composite Exhibit 1. Petitioner lives with [REDACTED]. *Id.* at 32. Petitioner is diagnosed with acid reflux/GERD, anemia, osteoarthritis, high blood pressure, high cholesterol, diabetes, dizziness, constant bladder incontinence, frequent bowel incontinence, kidney problems, osteoporosis, dementia, stent, unsteady gait, generalized weakness, and depression. *Id.* at 36 – 37.
3. 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 (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, and using transportation. *Id.* at 36. Petitioner needs assistance (but not total help) with using the telephone and managing medication. *Id.*

4. Petitioner requested an additional thirty-three (33) hours of personal care services, weekly. Petitioner's request was denied in the NABD dated June 15, 2020. *Id.* at 4-13. 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 an ongoing extra 33 hour/week of Personal Care Services to begin 07/01/2020 is denied as not medically needed. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs.

Id. at 4-5.

5. Petitioner requested a plan appeal and received an NPAR dated June 24, 2020, upholding the denial. *Id.* at 85-91. The NPAR explained as follows:

The reason for our decision was: The reconsideration of the request for an extra 33 hours per week of Personal Care Services is denied as not medically necessary. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 85.

6. On June 29, 2020, Petitioner requested a Fair Hearing due to a reduction of twelve (12) hours of personal care services. The above referenced NABD and NPAR regarding a denial of a request for additional personal care services was filed with the Office of Fair Hearings, but no documentation regarding a reduction in personal care services was filed. On August 5, 2020, the undersigned issued an Order to Show Cause why the request for Fair Hearing regarding a reduction of personal care services should not be dismissed, based upon the lack of documentation to show that the undersigned Hearing Officer has jurisdiction over Petitioner's request.

7. On August 25, 2020, the undersigned issued an Order Scheduling Hearing and Preliminary Instructions ("Scheduling Order"), scheduling a hearing to address whether the undersigned had jurisdiction to grant Petitioner's request for a Fair Hearing regarding the reduction of personal care services, and scheduling a Fair Hearing to address the denial of personal services issue. At the hearing, [REDACTED] testified that she had requested an appeal of the reduction of personal care services. Ms. Layne testified that Petitioner's request for an appeal was not made until August 27, 2020, and that the appeal was in progress. Accordingly, the undersigned concluded that the Office of Fair Hearings did not have jurisdiction to grant Petitioner's request for a Fair Hearing regarding a reduction of personal care services. *See infra* ¶ 22. [REDACTED]

stated that she wanted to proceed with the Fair Hearing on the issue of the denial of personal care services, and Respondent had no objections.

8. As of July 6, 2020, Petitioner's plan of care including twelve (12) hours of personal care services, weekly, and six (6) hours of homemaker services, weekly. See page 28 of Respondent's Composite Exhibit 1. On August 31, 2020, Respondent approved an additional twenty-five (25) hours of personal care services, weekly. *Id.* at 126. Thus, Petitioner's current plan of care now includes thirty-seven (37) hours of personal care services, weekly, and six (6) hours of homemaker care services, weekly.

9. Petitioner submitted a letter from [REDACTED], which stated as follows:

[Petitioner] has been our patient since [REDACTED] 2014. Patient is treated for multiple medical conditions including Memory Loss and Incontinence. She also has difficulty walking on her own. Patient can not [sic] be left alone under any circumstances due to these conditions.

Page 34 of Petitioner's Composite Exhibit 1.

10. As testified to by [REDACTED] at hearing, Petitioner's care aid is present from approximately 9:00 a.m. until 5:00 p.m., Monday through Friday. [REDACTED] works from Monday through Friday. [REDACTED] leaves for work each day at approximately 7:10 a.m. and returns home at 5:00 p.m.

11. As testified to by [REDACTED], Petitioner goes to bed around 10:00 p.m. each night and sleeps until the care aid arrives the next morning. It takes approximately forty (40) minutes to get Petitioner ready for bed. It takes approximately an hour and forty (40) minutes to get Petitioner woken, bathed, and dressed each morning.

12. As testified to by [REDACTED], [REDACTED] spends approximately four (4) hours each weekend running errands for herself and Petitioner. [REDACTED] explained that she cannot

take Petitioner with her due to Petitioner's difficulties with walking and because of concerns with COVID-19.

13. Dr. Carter is the Long Term Care Medical Director at Sunshine. Dr. Carter testified at hearing that, because Petitioner cannot move around the home, she is safe to be left alone for a three (3) to four (4) hour period.

CONCLUSIONS OF LAW

14. 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).

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

16. Because Petitioner is requesting a new service, Fla. Admin Code R. 59-1.100(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.)

17. Pursuant to Rule 59G-1.100(3), Florida Administrative Code, the Agency has jurisdiction and must provide a Fair Hearing for:

(a) A FFS recipient who makes a hearing request regarding:

1. The reduction, suspension, or termination by the Agency of a previously authorized service;
 2. The denial, in whole or in part, of a requested service or supply by the Agency;
- or
3. The failure of the Agency to provide a timely NOA subsequent to the Agency's failure to provide all medically necessary services to the recipient with reasonable promptness.

(b) An enrollee who makes a hearing request regarding:

1. A notice of plan appeal resolution indicating that the plan appeal did not result in the reversal of a prior denial of a new service, or the reduction, suspension, or termination of a previously authorized service, if timely challenged by the enrollee in accordance with the plan appeal procedures following the timely issuance of the plan's NABD to the enrollee;
 2. The failure of the plan to adhere to notice and timing requirements applicable to plan appeals; or
 3. The failure of the plan to timely notice the enrollee through a NABD, subsequent to the plan's failure to provide medically necessary services requested by the enrollee to the enrollee with reasonable promptness.
- (c) An enrollee who makes a hearing request regarding a disenrollment denial.
- (d) A recipient who receives notification from the Agency pursuant to Rule 59G-5.110, F.A.C. that a reimbursement request is denied in whole or in part.
- (e) A recipient entitled to a fair hearing pursuant to section 409.285(2), F.S.
- (f) The Agency need not grant a fair hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
- (g) A recipient who makes a hearing request regarding a denial or reduction to a medically necessary Florida Medicaid services and seeks corrective action.

18. Because the reduction, suspension, termination, or denial of a service or reimbursement request is a jurisdictional requirement for the Office of Fair Hearings, Fla. Admin. Code R. 59G-1.100(9)(b)(1) authorizes a hearing officer to deny or dismiss a request for a Fair Hearing if the Office lacks jurisdiction over the subject matter of the Fair Hearing request.

19. Furthermore, pursuant to Rule 59G-1.100(8)(e), Florida Administrative Code, an Enrollee must initiate and complete a plan appeal before making a Fair Hearing request unless the plan appeal was not properly noticed or is untimely. A plan appeal is a review by the Plan of an adverse benefit determination. The Enrollee may request a plan appeal by following the instructions at the bottom of the NABD. Once the Plan makes a determination regarding the plan appeal, it issues to the Enrollee an NPAR. The NPAR explains how to ask for a Fair Hearing if the Enrollee does not agree with the decision.

20. Because completion of a plan appeal is a jurisdictional requirement for the Office of Fair Hearings, Fla. Admin. Code R. 59G-1.100(9)(b)(2) authorizes a Hearing Officer to deny or dismiss

a request for a Fair Hearing if the Enrollee has not completed the plan appeal. Dismissal is without prejudice so that the Petitioner may properly request a Fair Hearing after completion of the plan appeal.

21. 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

...

4.2.1.9 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.

...

4.2.2.6 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.

22. 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.

23. 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.

24. 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:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- c. 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

- d. 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
- e. 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

...

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

Page 109-115 of Respondent's Composite Exhibit 1.

25. Petitioner requested an additional thirty-three (33) hours of personal care services, weekly. In the NABD, dated June 15, 2020, Respondent denied her request. *Id.* at 4 – 13. The NABD explains that “the member's currently approved services are adequate to meet the member's care needs.” *Id.* On August 31, 2020, Respondent approved an additional twenty-five (25) hours of personal care services, weekly, for the Petitioner. *Id.* As discussed, *supra* 7 and 8, Petitioner's request for a Fair Hearing was based on Respondent's alleged reduction of personal care services. An Order to Show Cause for Jurisdiction was issued on August 5, 2020, but Petitioner failed to provide an NABD or NPAR for a reduction of personal care services. A request for a plan appeal regarding a reduction of personal care services was made August 27, 2020,

which was after the Scheduling Order was issued. At the Fair Hearing, Ms. Layne testified that the appeal was still in progress. As no NABD or NPAR was provided to the Office of Fair Hearings regarding a reduction of personal care services, and regardless, Petitioner admits that the alleged plan appeal was not complete prior to making the Fair Hearing request, the undersigned concludes that the Office of Fair Hearing lacks jurisdiction for the issue of the reduction of personal care services. Thus, the only issue the undersigned Hearing Office has jurisdiction to address is whether Petitioner can show that Respondent's denial of eight (8) hours of personal care services was incorrect.

26. 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 assistance 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 bathing, dressing, using the bathroom, and transferring/mobility. Petitioner requires assistance (cannot do at all) with all IADLs, except for using the telephone, and managing medication. *Id.* at 35 and 36. Petitioner currently receives thirty-seven (37) hours of personal care services, weekly, and six (6) hours of homemaker care services, weekly.


27. As Petitioner bears the burden of proof, she must show that her request is 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.” Here, Petitioner’s receives forty-three (43) hours of combined services during the week, and those services are received from Monday through Friday each week. See ¶ 9. At all other times, Petitioner receives care from [REDACTED], who lives with her. [REDACTED] explained, *supra* ¶ 12, that she needs the extra services to allow her to run errands, as COVID-19 and Petitioner’s mobility problems make bringing Petitioner along difficult. According to Petitioner’s physician, Petitioner “can not [sic] be left alone under any circumstances” See page 34 of Petitioner’s Composite Exhibit 1. Accordingly, the record indicates that there may be compelling evidence for the need of additional hours of care to provide supervision of the Petitioner, but the evidence does not show that eight (8) additional hours are necessary to provide for Petitioner’s ADLs or IADLs, which is the purpose of personal care services.

28. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Petitioner/Respondent did not prove by a preponderance of the evidence that Respondent’s denial of eight (8) additional hours of personal care services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent’s denial of personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**. Petitioner’s request for a Fair Hearing regarding the reduction of personal care services is dismissed for lack of jurisdiction.

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

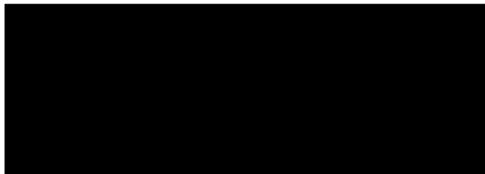
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JOSEPH MABRY, Hearing Officer
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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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