

All parties and witnesses appeared for the Fair Hearing telephonically. [REDACTED] (“Petitioner’s Authorized Representative” or “[REDACTED]”) appeared for the Fair Hearing to provide testimony on behalf of Petitioner and did not call any witnesses. Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. (“Sunshine Health”), appeared for the Fair Hearing as a representative for Respondent. The following persons appeared for the Fair Hearing as witnesses for Respondent: Jessica Nichols, Care Coordinator for Sunshine Health; Lisa Simshauser, LTC Supervisor for Sunshine; Alicia Swarts, Manager of Case Management for Service Area One for Sunshine; Melissa Layne, Senior Manager for Member Appeals for Sunshine Health; and Dr. John Carter (“Dr. Carter”), LTC Medical Director for Sunshine Health. Cindy Henline, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as an observer.

Petitioner’s Authorized Representative introduced an evidence packet containing four (4) pages, which was admitted into evidence as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 included the following: E-mail from [REDACTED] (dated October 20, 2020); Patient Instructions Report (printed on [REDACTED] 2020); and an Order Form from [REDACTED] [REDACTED] (undated).

Respondent introduced an evidence packet containing one hundred and thirteen (113) pages, which was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 included the following: Table of Contents; Medicaid Fair Hearing Summary (dated October 2, 2020); Notice of Adverse Benefit Determination (“NABD”) (dated August 26, 2020); Long Term Care Person-Centered Plan (“Previous Plan of Care”) (signed by Care Manager on August 10, 2020); Long Term Care Person-Centered Plan (“Current Plan of Care”) (signed by

Care Manager on August 27, 2020); Florida Department of Elder Affairs: 701B Comprehensive Assessment (“Previous 701B Assessment”) (dated August 10, 2020); Florida Department of Elder Affairs: 701B Comprehensive Assessment (“Current 701B Assessment”) (dated September 22, 2020); Expedited Appeal Request via email (dated September 9, 2020); Prescription from [REDACTED] (dated [REDACTED] 2020); Expedited Appeal Acknowledgment letter (dated September 10, 2020); Notice of Plan Appeal Resolution (“NPAR”) (dated September 11, 2020); Sunshine Health Policy and Procedure: LTC (Long Term Care) Ancillary Service Criteria (LT.UM.09) (“LTC Ancillary Service Criteria”); and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010 (166).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine Health’s Long-Term Care (“LTC”) Program. See Respondent’s Composite Exhibit 1, page 2. Sunshine Health is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.
2. Petitioner is a [REDACTED] year old woman residing in the community with a primary caregiver, [REDACTED]. *Id.* at 49-50; see also as reiterated by Dr. Carter at the hearing. Petitioner is diagnosed with Dementia. *Id.* at 51. Petitioner experiences the following health conditions: allergies; osteoarthritis; high blood pressure; high cholesterol; constant bladder incontinence; occasional bowel incontinence; kidney problems; seizure disorder; thyroid problems; and spinal stenosis. *Id.* at 55-56. Petitioner uses a walker for ambulation. *Id.* at 53. Petitioner is not on a special diet. *Id.* at 60. Petitioner is prescribed nine (9) medications. *Id.* at 61.

3. Petitioner needs assistance (but not total help) with Activities of Daily Living (“ADLs”) such as, bathing, dressing, eating, and using the bathroom. *Id.* at 53. Petitioner requires supervision or prompt and uses an assistive device for transferring and walking/mobility. *Id.* Petitioner needs total assistance with Instrumental Activities of Daily Living (“IADLs”) such as heavy chores, light housekeeping, managing money, and preparing meals, preparing meals, managing medication, using the telephone and using transportation. *Id.* at 54.

4. Prior to the reduction of Personal Care services, Petitioner received the following LTC services:

- Gloves – 1 box(es) monthly;
- Personal Care – 40 hour(s) Weekly;
- Wipes – 2 Pack(s) Monthly;
- Pull-ups – 2 Case(s) Monthly;
- Underpads – 1 Case(s) Monthly; and
- Personal Emergency Response System (PERS) – 1 Month(s) Monthly.

Id. at 29.

5. [REDACTED] (“[REDACTED]”) recommended “a complete 40 hour care at home due to multiple medical problems.” *Id.* at 68. [REDACTED] declared the continuation of home health care to be medically necessary. *See* Petitioner’s Exhibit 1, page 4.

6. Petitioner’s primary caregiver is [REDACTED]. *See* Respondent’s Composite Exhibit 1, page 63; *see* also as reiterated by Dr. Carter at the hearing. [REDACTED] works part-time outside of the home. *Id.*; *see* also as reiterated by Dr. Carter at the hearing. [REDACTED] does not have anyone to assist her in providing care. *Id.*

7. On August 25, 2020, Sunshine Health received Petitioner’s forty (40) hours per week of Personal Care services. *Id.* at 4-5. On August 26, 2020, Sunshine Health issued an NABD reducing

Petitioner's Personal Care services from 40 hours per week to 32 hours per week. *Id.* The NABD stated as follows:

We made our decision because:

(Check all boxes that apply)

- We determined that your requested services are **not medically necessary** because the services do not meet 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: Sunshine Health has looked at the member's present care needs and provided home services. The member's present care plan includes 40 hours/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 40 hours per week to 32 hours/week.** This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria

Id. (Emphasis added).

8. On September 11, 2020, Sunshine Health issued an NPAR denying Petitioner's plan appeal. *Id.* at 75-76. The NPAR stated as follows:

On September 9, 2020, we received your timely plan expedited appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated August

26, 2020, Notice of Adverse Benefit Determination Number [REDACTED], reducing the Personal Care Services (the person who helps bathe and dress you), from 40 hours/week to 32 hours/week, provided to [Petitioner].

On September 11, 2020, after consideration of the information you provided to Sunshine Health in support of your expedited plan appeal, Sunshine Health hereby denies your plan appeal. As a result, [Petitioner] will not receive the reduction of 8 hours per week of Personal Care Services (the person who helps bathe and dress you), effective September 11, 2020.

The reason for our decision was: The appeal to overturn the reduction of 8 hours per week of Personal Care Services (the person who helps bathe and dress you), from 40 hours per week to 32 hours per week, is denied for lack of medical necessity. **Based on the assessment, the currently approved 32 hours per week of Personal Care Services (the person who helps bathe and dress you) is adequate (enough) to meet your 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 Board Certified Physician in Internal Medicine.

Id. (Emphasis added).

9. On September 14, 2020, Petitioner's Authorized Representative timely requested a Fair Hearing to contest Respondent's reduction of Personal Care services.

10. At the hearing and under oath, Dr. Carter testified that the reduction of Personal Care services was based on the current 701-B Comprehensive Assessment. Respondent considered Petitioner's needs for ADLs and IADLs as well as Petitioner's natural support of [REDACTED]. Dr. Carter acknowledged that [REDACTED] works part-time outside of the home and testified that he considered her employment status in his medical necessity determination. Dr. Carter reviewed [REDACTED] recommendation of home care services, but disagrees with the recommendation.

11. At the hearing and under oath, [REDACTED] argued that Respondent's decision was incorrect because the 701-B Comprehensive Assessment does not reflect Petitioner's history of falls resulting in visits to the emergency room, and pain management services Petitioner is receiving for her back pain.

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

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

14. 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.

(Emphasis added).

15. Because Respondent reduced an existing service, the burden of proof is on the Respondent. *See* Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* 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 Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs LTC services available to eligible Medicaid recipients in the State of Florida.

The 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.

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 covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the 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 restrictive setting

...

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.

17. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines Medically Necessary or Medical Necessity as:

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.

18. In making a medical necessity determination, Respondent relied upon their internal policy, the LTC Ancillary Service Criteria . See Respondent's Composite Exhibit 1, pages 82-111.

The LTC Ancillary Service Criteria states as follows regarding Personal Care services:

1. Determinants for Services

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)

- Independent where member is able to provide the task without support, with or without assistive devices
- Minimal functional impairment where the ADL's require one of the following:
 - Supervision
 - At least minimum assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance
- Moderate functional impairment where two of the follow apply
 - Member has ADLs requiring at least minimal assistance
 - Member ambulates with assistance of a person or device
 - Member transfers require at least minimum assistance
- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
 - Member has ADLs requiring total assistance
 - Member is non-ambulatory
 - Member transfers require one (1) to two (2) person assist
 - Member's treating physician has certified that member meets Maximum unctional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member).
- Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

The criteria for each ancillary service is described below:

...

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 not administer any medications, but may bring

- medications to the member and remind the member to take the medicine 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.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location.

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

See Section C.1 for more detail

Covered Personal Care services may include:

- a) Bathing - Assistance with bathing, including washing, rinsing, and drying the body or body parts.
 - Member's ability to transfer in and out of the tub or shower
 - Amount of time it takes the member to transfer in and out of the tub or shower
 - Ability of member to prepare the shower or run the bath water
 - Ability of member to use any assistive devices, such as a grab-bar or shower chair
 - Ability of member to use a sponge or wash cloth to clean himself/herself
 - How many times per week does the member bathe, consider that:
 - Incontinence episodes resulting in the need for a bath
 - Daily bathing of the elderly is not recommended due to damage that occurs to the skin from the water and the soap
 - Bathing more than once per day is a personal preference and not a necessity.
 - Full bath (bathtub, shower, or bed bath) or partial sponge bath (washing of face, underarms, and private areas).
 - A bed bath for members who are bed bound and cannot get out of the bed to be bathed in a shower or tub

- b) Dressing and Grooming - Dressing assistance includes the laying out, taking off, putting on, and fastening of clothing and footwear, and includes:
- Member's ability to choose their own clothes, put them on, and put on socks and shoes
 - Ability to put clothes, socks and shoes on if someone lays out the clothes
 - Ability to button, zipper, tie, or buckle clothes or shoes
 - Ability to successfully use assistive devices in dressing, such as reachers, sock pullers, or shoehorns
 - Ability to dress self in the morning or evening to get ready for bed

Grooming includes assessment of member's ability to:

- Comb or brush hair
- Shave
- Complete oral hygiene, including brushing teeth, remove dentures/partials, clean dentures/partials, and replace dentures/partials
- Trim and clean fingernails and toenails
-

- c) Eating and Feeding Considerations – Eating/Feeding is the process of a member getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into their body after it is cooked or prepared for eating. (This does not include tube feeding as that is considered a skilled task.) Includes an assessment of the member's ability to:

- Cut foods into appropriate size pieces
- Move food or drink from the serving receptacle to their mouth

Support for eating considers the number of meals per day that the member eats.

Note: Assistance with the preparation of meals is considered as part of Meal Preparation

- d) Toileting Considerations

- Taking off and putting on of clothing and/or diapers,
- Post-toilet hygiene
- Use of equipment, such as a urinal or bedpan
- Emptying of urinal or bedpan
- Cleaning of a catheter or ostomy bag
- Reminders or a toileting schedule

- e) Transferring Considerations - Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. It includes an assessment of the member's:

- Ability to use any mechanical devices such as a walker, cane, handrails, or wheelchair to assist with transfers
 - Ability to safely transfer without the assistance of another person
 - Ability to physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver
- f) Mobility Considerations – Mobility is the extent of the member’s purposeful movement within their residence. It includes an assessment of the member’s:
- Ability to purposely move about his/her residence independently with or without the use of assistive devices, this includes the ability of a member to move around in a wheelchair
 - Movements being unsafe without the assistance of another person in ambulating
 - Muscle weakness, unstable gait or unstable balance

...

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:
 - a. Member requires frequent repositioning due to wounds
 - b. Severe incontinence requiring multiple overnight changes and cleaning
5. Services provided by Sunshine Health may not duplicate services that are provided under by another provider.
6. Escort Services

See Respondent’s Composite Exhibit 1, pages 82-111.

19. Based on the NABD and the NPAR, Respondent reduced Petitioner’s Personal Care services from 40 hours per week to 32 hours per week based on medical necessity. See supra ¶ 7-8. Respondent determined that 8 hours per week no longer medically necessary based “on the assessment of the member’s care needs and household and caregiver status.” See supra ¶ 7. Respondent declared that 32 hours per week of Personal Care services were sufficient to meet the Petitioner’s needs. See supra ¶ 8. Dr. Carter added that the Petitioner’s needs for ADLs and

IADLs as well as Petitioner's natural support of [REDACTED] addressed in the 701-B Comprehensive Assessment led to the reduction of services.

20. Personal Care services 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* ¶ 16. Personal Care services are covered by the LTC Policy if they are determined to be medically necessary. *See supra* ¶ 16. Because Personal Care services are classified under mixed services, the medical necessity criteria outlined in Fla. Admin. Code R. 59G-1.010 applies in this instance. *See supra* ¶ 16. Section 2.83 of the Definitions Policy outlines the five criteria that must be met for a service to be medically necessary. *See supra* ¶ 17. Based on the record, Respondent determined that the following medical necessity standard has not been met for a continuation of services: Services must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs. *See supra* ¶ 7-8, 10. This specific medical necessity standard is required to be met by the Definitions Policy. *See supra* ¶ 16.

21. The record indicates that Personal Care services are not in excess of the Petitioner's needs. Dr. Carter asserted that the following information led to the reduction of services: the Ccurrent 701-B Comprehensive Assessment; Petitioner's needs for ADLs and IADLs; Petitioner's natural support of [REDACTED]; and [REDACTED] employment status. *See supra* ¶ 12. However, Dr. Carter did not present any evidence or testimony with respect to how this information translated to a medical necessity determination. Dr. Carter did elaborate about how or why this information means that 8 hours per week of Personal Care services are in excess of the Petitioner's needs. No testimony was presented regarding a change in Petitioner's needs for

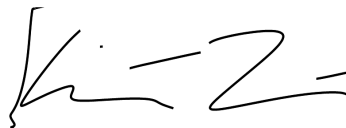
assistance with ADLs or IADLs. Further, no testimony was presented regarding how [REDACTED] employment schedule allows Petitioner to receive more natural support to the extent that Petitioner no longer needs 8 hours per week of Personal Care services. In addition, the Current 701-B Comprehensive Assessment does not provide clarity as to how 8 hours per week of Personal Care services were no longer needed, and Dr. Carter provided insufficient testimony at the hearing to explain why 8 hours per week of Personal Care services were no longer needed. Based on the record, Respondent has not demonstrated that the Personal Care services at issue (8 hours per week) are in excess of Petitioner's needs at this time.

22. Accordingly, upon consideration of the evidence admitted into the record, the parties' sworn testimony, the LTC Policy, and the Definitions Policy, the undersigned concludes that Respondent has not shown that 8 hours per week of Personal Care services are no longer medically necessary. Thus, Respondent has not shown by a preponderance of the evidence that Respondent's reduction of Personal Care services was correct.

DECISION

Respondent's reduction of Petitioner's Personal Care services is **REVERSED**. Petitioner's request for relief is hereby is **GRANTED**.

DONE AND ORDERED this 16th day of November, 2020, in Tallahassee, Leon County, Florida.



Digitally signed by
Kristopher León
Reason: 20-FH [REDACTED]
Date: 2020.11.16
11:23:55 -05'00'

KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11

Tallahassee, FL 32308-5407

Office: (850) 412-3649

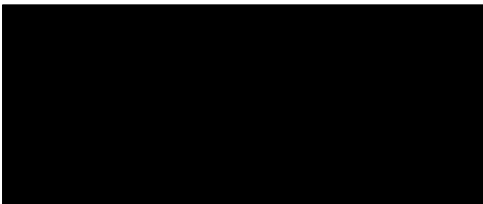
Fax: (850) 487-1423

Email: OfficeOfFairHearings@ahca.myflorida.com

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:



Sunshine Health
SunshineHealth_MFH@centene.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com.