



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

**FILED**

Dec 01, 2020, 8:24 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 Hearing Officer convened a telephonic Medicaid Fair Hearing on November 4, 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 Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services from 40 hours per week to 32 hours per week was correct.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and father, appeared for the Fair Hearing and provided testimony on Petitioner’s behalf.

Maria Mojica (“Ms. Mojica”), Compliance Specialist for Sunshine State Health Plan, Inc. (“Sunshine” or “Respondent”) represented Respondent at the hearing. The following individuals appeared on behalf of Respondent: Dr. John Carter (“Dr. Carter”), Long Term Care (“LTC”) Medical Director for Sunshine; Lakisha Hughes, Care Coordinator Supervisor for Sunshine; Tammy Swan, Senior Director of LTC for Sunshine; Alshenetha Williams, Care Coordinator Supervisor for Sunshine; Maria Palacio, Care Coordinator for Sunshine; and Melissa Layne, Senior Manager for Member Appeals for Sunshine.

Chrissie Simmons, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, Petitioner did not to the Office of Fair Hearings and Respondent an evidence packet. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 182-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Table of Content; a Medicaid Fair Hearing Summary, dated October 9, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated August 13, 2020; Sunshine’s LTC Person-Centered Care Plan (“care plan”), signed by the Care Manager on August 3, 2020; the care plan, signed by the Care Manager on September 30, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of August 3, 2020 (the “8/3/20 701B”); the 701B with an assessment date of September 30, 2020 (the “9/30/20 701B”); an email from [REDACTED], dated August 25, 2020; a letter from [REDACTED], dated June 8, 2018;

Petitioner's medical records for [REDACTED], 2019, [REDACTED], 2016, and [REDACTED], 2008; a letter from the Social Security Administration, dated [REDACTED] 2018; a 59-page facsimile transmission ("fax") from [REDACTED] to Sunshine, dated August 26, 2020; Sunshine's Standard Appeal Acknowledgment, dated August 31, 2020; a Notice of Plan Appeal Resolution ("NPAR") dated, September 16, 2020; the Sunshine Health Policy and Procedure LT.UM.9; and Fla. Admin. Code R. 59G-1.010. Absent an objection from Petitioner, the undersigned admitted Respondent's 182-page evidence packet into evidence as Respondent's Composite Exhibit 1.

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of Sunshine's LTC plan. *See* Respondent's Composite Exhibit 1, page 2. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is a 31-year-old male who resides in a private residence with his parents. *See* Respondent's Composite Exhibit 1, pages 49 – 50. The 9/30/20 701B, which is the most recent 701B, reflects that Petitioner "has diagnosis of Mental Retardation and Autism." *Id.* at 50. The 9/30/20 701B provided the following information about Petitioner:

Member is alert and oriented mostly to self. He is mostly non-verbal and uses gestures to communicate. He requires Moderate to Total assist with all ADLs and IADLs. He is unable to maintain his own hygiene. Member has no physical limitations or restriction. Parents plan to care for member at home. They will continue to provide care through PDO.

...

Member has diagnosis of mental retardation and autism. He needs assistances but no total help to participate in ADLs. Mother assists, prompt, and supervises as needed.

with bathing, dressing, toileting and all grooming. Caregiver also prepares all meals and sets them up for him and supervises member while he eats. Member is able to feed self.

Member is independent with transfers and ambulation but has to be supervised due to wandering. Parents plan to care for member at home and have elected

PDO.

Caregiver reports member makes messes and is not capable of following a routine.

...

Member is mentally delayed and needs supervision 24/7.

...

Member is reported to have good appetite. He is not able to prep any meals. Parents put a safe/lock to the refrigerator to avoid member eating without control. Parents will continue to assist with meal prep and set up. PCP monitors weight. No concerns at this time.

...

Respondent's Composite Exhibit 1, pages 50, 53, 58 and 60.

3. The 9/30/20 701B reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner requires no assistance with eating, transferring, and walking/mobility. See Respondent's Composite Exhibit 1, page 53. Petitioner needs assistance (but not total help) with bathing, dressing, and using the bathroom. *Id.* Petitioner is not incontinent of bowel or bladder. *Id.* at 55.

4. The 9/30/20 701B reflects the following regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"). Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, and preparing meals. See Respondent's Composite Exhibit 1, page 54. Petitioner needs assistance (but not total help) with managing medication and using transportation. *Id.*

5. On August 13, 2020, Respondent issued an NABD reducing personal care services from 40 hours per week to 32 hours per week. See Respondent's Composite Exhibit 1, pages 4 and 5. The NABD stated the reason for Respondent's determination was that the "requested services are **not medically necessary.**" *Id.* at 4.

6. Petitioner timely requested a plan appeal. See Respondent's Composite Exhibit 1, page 138. On September 16, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 144 – 146. The NPAR stated as follows:

On August 25, 2020 we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated August 13, 2020, Notice of Adverse Benefit Determination Number [REDACTED], REDUCING the personal care services from 40 hours per week to 32 hours per week provided to [Petitioner].

On September 16, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby DENIES your plan appeal. As a result, [Petitioner] will not receive the additional 8 hours of personal care services that have been reduced, effective September 16, 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 (not needed). Based on the assessment, the member's currently approved services are adequate (enough) to meet the member's care needs. The member's present care plan includes 32 hours per week of Personal Care Services (the person who helps bathe and dress you). 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 a Board Certified Physician in Internal Medicine.

See Respondent's Composite Exhibit 1, page 144.

7. On September 24, 2020, Petitioner requested a Fair Hearing due to the reduction of personal care services from 40 hours per week to 32 hours per week. The undersigned scheduled the Fair Hearing for November 4, 2020, at [REDACTED] and all parties were duly notified.

8. Dr. Carter is an LTC Medical Director for Sunshine. Dr. Carter testified that Respondent reduced Petitioner's personal care services, because he lives in the home with his father and mother, neither parent works outside the home, and 32 hours per week of personal care services is enough to provide for Petitioner's needs. Petitioner's personal care services are provided

through the Patient Direct Option service delivery model, and Petitioner's mother is his direct service worker who provides Petitioner's personal care services.

9. [REDACTED] is Petitioner's father. Petitioner resides in the home with [REDACTED], Petitioner's mother, and a minor sibling. [REDACTED] is 65 years old and has back/spine problems, but he is able to walk. Petitioner's mother rarely leaves the house, but when she does leave the house, the whole the family leaves together. An alarm in the home notifies the family when Petitioner wakes up at night, so that Petitioner can be supervised.

#### **CONCLUSIONS OF LAW**

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statute § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

12. 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.

13. Because Respondent is reduction existing services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. 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.).

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

**1.1 Description and Program Goal**

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

...

**1.3 Definitions**

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

**1.3.1 Activities of Daily Living (ADLs)**

ADLs include:

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

...

**1.3.5 701-B Comprehensive Assessment**

An individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

### **1.3.9 Instrumental Activities of Daily Living (IADLs)**

When necessary for the recipient to function independently, including:

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

...

### **1.3.14 Medically Necessary or Medical Necessity**

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

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

And, one of the following:

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

...

### **1.3.16 Natural Supports**

Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

### **1.3.18 Plan of Care**

A description of the enrollee's goals for long-term care, the services and supports needed to meet those goals, and the specific service needs of each enrollee, showing the projected duration, desired frequency, and type of provider furnishing each service, and the scope of the services to be provided.

...

## **2.2 Who Can Receive**

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

...

## **4.0 Coverage Information**

### **4.1 General Criteria**

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

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

### **4.2 Specific Criteria**

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

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

...

#### **4.2.2.6 Personal Care**

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

...

## **6.0 Documentation**

...

### **6.2 Specific Criteria**

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

See SMMC LTC Policy, pages 1-8.

15. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, states as follows:

**1.0 Introduction**

This policy contains definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule.

...

**2.18 Caregiver**

Person(s) attending to the needs of another person, who is physically or mentally impaired, injured, incapacitated, or a child unable to care for him or herself.

...

**2.2 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

...

**2.32 Covered Services**

Medical and allied care, goods, services, or procedures that are reimbursable by Florida Medicaid.

...

**2.64 Instrumental Activities of Daily Living (IADLs)**

IADLs include:

- 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)

...

**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.

See Definitions Policy, pages 1, 2, 3, 6 and 7.

16. In the instant case, Respondent reduced Petitioner's personal care services from 40 hours per week to 32 hours per week. See supra ¶ 5. As established on the record by the evidence and testimony, Respondent reduced Petitioner's personal care services, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. See supra ¶ 5 and 6.

17. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the SMMC LTC Policy; do not duplicate another service; and meet the criteria as specified in the SMMC LTC Policy. See supra ¶ 14. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are "[t]o provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are

incidental to the care furnished or are essential to the health and welfare of the enrollee.” See supra ¶ 14.

18. The evidence presented in this case reflects that Respondent’s reduction of personal care services is warranted under the circumstances of this case. Specifically, Regarding ADLs, Petitioner requires: no assistance with eating, transferring, and walking/mobility; and assistance (but not total help) with bathing, dressing, and using the bathroom. See supra ¶ 3. Regarding IADLs, Petitioner needs: total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, and preparing meals; and assistance (but not total help) with managing medication and using transportation. See supra ¶ 4. Petitioner “has diagnosis of Mental Retardation and Autism.” See supra ¶ 2. Petitioner is not incontinent of bowel or bladder. See supra ¶ 3. Petitioner “needs supervision 24/7.” See supra ¶ 2. However, Petitioner resides in the home with his parents. Neither parent works outside the home. See supra ¶ 2, 6 and 8. Petitioner’s mother is his direct service worker who provides Petitioner’s personal care services. See supra ¶ 8. Petitioner’s mother rarely leaves the house, but when she does leave the house, whole the family leaves together. See supra ¶ 9. An alarm in the home notifies the family when Petitioner wakes up at night, so that Petitioner can be supervised. See supra ¶ 9. The record reflects that “Parents put a safe/lock to the refrigerator to avoid member eating without control.” See supra ¶ 2. Based upon the evidence presented by both parties, Respondent established that a reduction of personal care services was warranted in this matter.

19. Section 1.3.16 of the SMMC LTC Policy provides that natural supports are “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” See supra ¶ 14. Petitioner resides in the home with his parents. Neither

parent works outside the home. See supra ¶ 2, 6 and 8. ██████████ is 65 years old and has back/spine problems, but he is able to walk. *Id.* Further, the record does not reflect that ██████████ is physically incapable of providing minimal or minor assistance to Petitioner. Therefore, Petitioner has natural supports available to assist with his care and needs.

20. Additionally, section 1.3.14 of the SMMC LTC Policy requires that “LTC supportive services must . . . [b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See supra ¶ 14. The NPAR explains that “[b]ased on the assessment, the member's currently approved services are adequate (enough) to meet the member's care needs.” See supra ¶ 6. Considering the LTC Policy’s definitions for natural supports and personal care services, *supra* ¶ 14, Respondent demonstrated that Petitioner’s aforementioned needs, *supra* ¶ 2 – 4, and 9, are sufficiently met by the 32 hours per week of personal care services. Given that Respondent established that the reduction of personal care services is warranted in this matter, *supra* ¶ 18, the requested 40 hours per week of personal care services is “in excess of [Petitioner’s] needs.” See supra ¶ 14.



21. In light of the both parties’ testimony, Respondent’s Composite Exhibit 1, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent met its burden of proving that the reduction of personal care services from 40 hours per week to 32 hours per week is medically necessary.

22. Accordingly, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent’s reduction of personal care services was correct.

### **DECISION**

Respondent's reduction of personal care services from 40 hours per week to 32 hours per week is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction in this matter is **DENIED**.

**DONE AND ORDERED** this 1st day of December, 2020, in Tallahassee, Leon County, Florida.

 Tracie Hardin  
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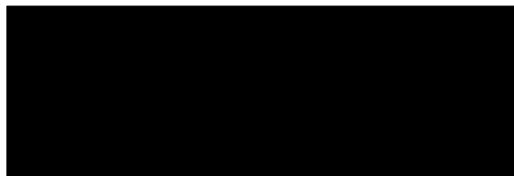
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**TRACIE HARDIN, Hearing Officer**  
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**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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.

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