STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

FULL HEALTH CARE, INC., Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	Case No. 00-4441

RECOMMENDED ORDER

The parties having been provided proper notice, Administrative Law Judge John G. Van Laningham of the Division of Administrative Hearings convened a formal hearing of this matter in Miami, Florida, on March 21, 2001. The hearing was adjourned on March 22, 2001.

APPEARANCES

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STATEMENT OF THE ISSUE

The issue for determination is whether Petitioner must reimburse Respondent for payments totaling $193,232.50 that Petitioner admittedly received between January 1, 1999, and June 15, 2000, under the Medicaid Program for the provision of universal precaution kits to AIDS patients, where the supplies in question allegedly were not specifically listed in the patients' respective plans of care.

PRELIMINARY STATEMENT

Respondent Agency for Health Care Administration (the "Agency") is the agency responsible for administering the Florida Medicaid Program. Petitioner Full Health Care, Inc. ("Full Health") is a licensed home health agency which is enrolled as a Medicaid provider. Full Health is also enrolled as a provider under the Project AIDS Care Waiver program, a special Medicaid program that provides home and community-based services to patients with AIDS.

On August 17, 2000, the Agency issued a Final Agency Audit Report demanding that Full Health reimburse the Agency $209,432.50 in alleged Medicaid overpayments for certain services (home-delivered meals, pest control, and the provision of disposable medical supplies) that Full Health had furnished to AIDS patients between January 1, 1999, and June 15, 2000.

By letter dated September 7, 2000, Full Health timely requested a formal administrative hearing, and the Agency referred the matter to the Division of Administrative Hearings. Thereafter, the parties were duly notified that a final hearing would begin at 9:30 a.m. on March 21, 2001, at the Dade County Courthouse in Miami, Florida. Both sides appeared at the scheduled time and place; the final hearing lasted two days.

At the outset of the hearing, the parties executed and filed a Prehearing Stipulation confirming the parties' agreement that the challenged Medicaid "reimbursement [of Full Health] for home-delivered meals and pest control services was appropriate." This effectively narrowed the issue to whether, under the circumstances, Full Health's provision of $193,232.50 worth of disposable medical supplies (namely, universal precaution kits) was a Medicaid-compensable service.

Full Health presented three witnesses and proffered five exhibits, Petitioner's Exhibits 1, 2 (composite), 3, 3B, and 3C, all of which were received. Petitioner's witness were: Judith Klein, an Agency employee who had conducted a licensure survey of Full Health; Elizabeth Crowley, R.N., a registered nurse who testified as an expert on home health agency practices; and Mayelin Gonzalez, Full Health's President.

The Agency presented two witnesses, Amy Rolon and Adolfo Garcia, both Agency employees who had been personally involved in the Medicaid audit of Full Health. The Agency also introduced 62 exhibits, identified as Respondent's Exhibits 2, 3, 9, 12, 13-69, and 74, into evidence.

Respondent's Exhibits 13 through 69 are Full Health's patients' plans of care for the relevant time period. These were admitted in evidence over Full Health's vigorous hearsay objection. At hearing, the Administrative Law Judge deemed these documents to be hearsay and expressed doubt that the Agency had laid a predicate for introducing them under a recognized exception to the hearsay rule. Nevertheless, the Administrative Law Judge believed that the exhibits might be useful as secondary evidence in accordance with Section 120.57(1)(c), Florida Statutes, and received them on that basis. In addition, in view of the potential significance of the plans of care and the closeness of the question, the Administrative Law Judge reserved ruling on whether a properly-established hearsay exception would permit the documents to be considered competent evidence for all purposes and invited the parties to address the evidentiary issues in their respective post-hearing submissions. The parties complied, and a ruling on the subject in contained in this Recommended Order.

A transcript of the final hearing was filed with the Division on April 25, 2001. The parties timely filed proposed recommended orders, and these papers were carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

The evidence presented at final hearing established the facts that follow.

The Parties and the Stake

1. The Agency is responsible for administering the Florida Medicaid Program. As one of its duties, the Agency must recover "overpayments . . . as appropriate," the term "overpayment" being statutorily defined to mean "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." See Section 409.913(1)(d), Florida Statutes.

2. This case arises out of the Agency's attempt to recover alleged overpayments from Full Health, a Florida-licensed home health agency. As an enrolled Medicaid provider, Full Health is authorized, under a provider agreement with the Agency, to provide services and supplies to Medicaid recipients.

3. It is undisputed that, at all times material to this proceeding, Full Health was authorized to provide home and community-based ("HCB") services and supplies to Medicaid recipients eligible for assistance under a program—more about which below—called the Project AIDS Care Waiver ("PAC Waiver").

4. The "audit period" that is the subject of the Agency's recoupment effort is January 1, 1999 to June 15, 2000. It is undisputed that, during this audit period, the Medicaid Program reimbursed Full Health a total of $193,232.50 for "universal precaution kits" (packages containing disposable protective gear such as latex gloves, surgical masks and gowns, and eye shields) that Full Health had delivered to 57 clients in the PAC Waiver program. The Agency contends that the entire $193,232.50 is subject to recoupment because, under the PAC Waiver program, case manager approval is a necessary precondition to Medicaid reimbursement, and none had been given for the universal precaution kits at issue.

PAC Waiver Program Basics

5. Broadly speaking, the State of Florida has obtained waivers from certain federal Medicaid requirements to allow for the provision of specified HCB services to patients at risk of institutionalization. See Rule 59G-8.200(1), Florida Administrative Code. The PAC Waiver program is one of six authorized HCB services waiver programs. Rule 59G-8.200(9), Florida Administrative Code.[1]

6. The PAC Waiver program "provides a range of HCB services designed to meet the needs of people living with AIDS related conditions." Rule 59G-8.200(14)(a), Florida Administrative Code. To be eligible for benefits under the PAC

Waiver program, a recipient must satisfy a number of criteria, including having been diagnosed with AIDS. Rule 59G-8.200(14)(c)2, Florida Administrative Code.

7. The Florida Medicaid office has prepared and furnishes to authorized Medicaid providers a manual entitled Project AIDS Care (PAC) Waiver Services Coverage and Limitations Handbook (the "Handbook"). In their joint Prehearing Stipulation, the parties agreed that the April 1999 version of the Handbook was in effect during the audit period, and this stipulation is accepted as fact.

8. The Handbook does not appear to have been incorporated by reference into the Florida Administrative Code as an Agency rule.[2] Full Health, however, has not challenged the Agency's reliance on the Handbook as an authoritative source of the policies and procedures relating to reimbursement for services provided under the PAC Waiver program. To the contrary, not only did Full Health stipulate that the April 1999 Handbook was "in effect" during the relevant period, but also it introduced the entire April 1999 Handbook into evidence as Petitioner's Exhibit 1.

9. In addition, Full Health's President, Ms. Gonzalez, credibly described Petitioner's Exhibit 1 as the place "where you find all of the rules and regulations that you have to follow when it comes to this kind of patients [sic] [meaning PAC

Waiver recipients]." Transcript of Final Hearing at 461. The trier believes Ms. Gonzalez's testimony on this point and adopts it as a fact. For purposes of this case at least, the Handbook sets forth pertinent, applicable Medicaid policies and claims processing requirements. See Rule 59G-8.200(14)(f), Florida Administrative Code ("Medicaid will make payment for services provided to Project AIDS Care recipients in accordance with applicable Medicaid claims processing requirements.").[3]

10. As the Handbook explains, "[e]very PAC waiver recipient must have a case manager who is employed by a Medicaid-enrolled PAC waiver case management agency." Handbook at 2-1.[4] See also Rule 59G-8.200(14)(c)6., Florida Administrative Code (patient must have a case manager to be eligible under this waiver).

11. Among the case manager's responsibilities is the development of a "plan of care" for each PAC Waiver patient. "A plan of care is a written document that describes the service needs of a recipient, specifies the services to be provided, the provider of services, how frequently the services are to be provided, the duration of the services, and their estimated cost." Handbook at 2-7. The case manager is required to "review plans of care on an ongoing basis, but no less frequently than every six months." Rule 59G-8.200(14)(e)1.d., Florida Administrative Code.

12. Significantly, the "plan of care and the services specified in the plan of care are considered authorized when [the plan of care] is signed by the case manager." Handbook at 2-9. The case managers, however, do not have carte blanche to approve services. Rather, their discretionary approval authority is capped at $2,000 per month per patient, and "Medicaid must approve plans of care exceeding a cost of $2,000 per month before services are considered authorized." Handbook at 2-9. Indeed, "[i]f the total estimated cost of the Project AIDS Care services exceeds [this monthly limit], prior approval must be obtained from Medicaid before the service authorizations can be made." Rule 59G-8.200(14)(e)1.d., Florida Administrative Code.

13. Case manager approval, as manifested in a signed plan of care for the individual patient, is <u>essential</u>. Without it, HCB services rendered to a PAC Waiver patient are <u>not</u> Medicaid compensable, regardless of medical necessity, efficacy, the provider's competence or good intentions, or any other compelling justification. The Handbook is blunt and unambiguous about this: "Services not specified in the plan of care are not considered approved or authorized. <u>Medicaid reimbursement for services furnished, but not specified in the plan of care for that specific time period are subject to recoupment</u>." Handbook

2-9 (emphasis added); see also Rule 59G-8.200(6)(g), Florida Administrative Code.

14. The Handbook further informs providers:

> PAC waiver services are based on individual recipient needs and must be in the recipient's plan of care. All recipients enrolled in the PAC waiver must receive case management and at least one other waiver service.
>
> Medicaid will reimburse only waiver services that are specifically identified in the approved plan of care by service type, frequency and duration.

Handbook at 2-12 (emphasis added).

15. The case manager performs another crucial function in the delivery of services to PAC Waiver recipients: he or she instructs participating providers (such as Full Health) to commence furnishing an approved service or services to a particular patient. The case manager's instructions to the provider must be in writing on an instrument known as "service authorization." The applicable administrative rule directs:

> The case manager shall develop written service authorizations for all services except case management. These authorizations will provide sufficient information to allow the provider to bill for services with a minimum of assistance. The authorizations will parallel the plans of care in terms of specificity of the service, the duration of the service, frequency of service, and the total authorized amount to be spent. If a case manager authorizes a service orally, he will send a written authorization to the provider

> within five working days as confirmation of the oral authorization.

Rule 59G-8.200(14)(e)1.e., Florida Administrative Code.

16. The Handbook amplifies the foregoing rule provision, explaining that

> [i]n order to implement services authorized on a plan of care, the case manager must transmit service authorizations to specific providers of PAC waiver services included in the plan of care.
>
> Service authorizations must be sent to PAC waiver services providers within five working days of services being authorized on the recipient's written plan of care.

Handbook at 2-10.

17. Included with the Handbook, in Appendix C, is a Service Authorization form that case managers are encouraged to use. The instructions for use of this form state, in pertinent part, as follows:

> The case manager should notify providers that services have been authorized by using the PAC Service Authorization form. Each enrolled Medicaid PAC program service provider must receive authorization before providing services to the PAC client. The authorization form includes the following: Make sure that all authorized services are contained in the current plan of care and that the services are based on needs identified in the needs assessment and that the level of service is justified in the case narrative.

Handbook, Appendix C (boldface in original).

18. The Service Authorization form reminds the provider that "[s]ervices beyond the amount, duration, and scope authorized [hereby] will not be reimbursed." Handbook, Appendix C (boldface in original).

19. Individuals eligible for assistance under the PAC Waiver program may receive a number of covered services, including the provision of "consumable medical supplies." See Rule 59G-8.200(14)(b)4., Florida Administrative Code (setting forth qualifications needed to provide consumable medical supplies under PAC Waiver program).

20. The term "consumable medical supplies" is defined by rule to mean "expendable, disposable, and non-durable items used for the treatment of specific injuries or diseases or for persons who have chronic medical or disabling conditions. These supplies exceed those routinely furnished by the provider in conjunction with skilled care and home health aide visits." Rule 59G-8.200(2)(h), Florida Administrative Code (emphasis added).

21. The Handbook defines "consumable medical supplies" somewhat differently, incorporating several elements of the rule (expendable, disposable, non-durable) and adding to them a gloss that affords a fuller description of the covered items:

> Consumable medical supplies are medically-necessary medical or surgical items that are consumable, expendable, disposable or non-

> durable, and appropriate for use in the recipient's home. <u>Medicaid only reimburses consumable medical supplies that if not provided could reasonably cause the recipient to require emergency treatment, become hospitalized, or be placed in a long-term care facility.</u>
>
> Consumable medical supplies must not exceed one month's usage.

Handbook at 2-35 (emphasis added).

22. Consumable medical supplies fall within a Medicaid billing category called "Specialized Medical Equipment and Supplies" that is denoted by the procedure code W9994. Also included in this category of services is durable medical and adaptive equipment which "is medically-necessary . . . and can withstand repeated use . . . in the recipient's home." Handbook at 2-34. Examples of the latter are mattresses, humidifiers, and wheelchairs.

23. Medicaid will reimburse a provider of specialized medical equipment and supplies only for items furnished that are (1) "[s]pecifically identified in the recipient's plan of care" and (2) "[p]rescribed by a licensed physician, advanced registered nurse practitioner, or physician assistant designee." Handbook at 2-34.

24. All Medicaid providers, including case managers and home health agencies such as Full Health, must "retain medical, professional, financial, and business records pertaining to

services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours." Section 409.913(8), Florida Statutes; see also Section 409.907(3)(c), (e), Florida Statutes (prescribing provisions respecting records retention and review for inclusion in Medicaid provider agreements).

25. By rule, the Agency specifically requires that case managers retain plans of care and service authorizations, among other documents, in their files. Rule 59G-8.200(14)(e)2.f., g., Florida Administrative Code. The files of other participating provider agencies, such as Full Health, must contain at least the service authorizations, provider eligibility documents, and provider enrollment documents. Rule 59G-8.200(14)(e)3., Florida Administrative Code.

Full Health's Provision of Universal Precaution Kits During the Audit Period

26. Full Health delivered the universal precaution kits at issue to 57 PAC Waiver recipients between the dates of November 15, 1999, and May 10, 2000—a period of about six months (the "Focal Period") that comprises a subset of the audit period. Ms. Gonzalez has been employed by Full Health since October 1999 as the company's President, a position she held,

therefore, during the entire Focal Period. Her extensive testimony on Full Health's business practices regarding the provision of universal precaution kits was believable and forms the primary basis of the fact findings set forth in this section of the Recommended Order.

27. During the Focal Period, Full Health automatically furnished universal precaution kits to all PAC Waiver recipients in the ordinary course of its business. Full Health followed this routine in part to comply with doctors' orders that were communicated directly to Full Health verbally but never reduced to writing, and also because Ms. Gonzalez understood that the routine provision of universal precaution kits to AIDS patients was a generally accepted, standard practice in the medical community, one that home health agencies customarily observed.

28. As a matter of course, then, Full Health delivered universal precaution kits to each patient once a week, and a week's supply for each patient might consist of multiple universal precaution kits. Full Health thereafter would submit claims to Medicaid for payment on each individual universal precaution kit delivered, at a cost of $55.00 apiece, reporting a separate date of service for every single one. For example, during the month of January 2000, Full Health delivered 27 universal precaution kits to a patient named J.G. Full Health's subsequent Medicaid claims showed that J.G. had received this

$55.00 service on each day of the month (including New Year's Day) except January 9, 16, 23, and 30—all Sundays.

29. Full Health received not one service authorization for any of the universal precaution kits it delivered to PAC Waiver patients during the Focal Period. Indeed, these 57 patients' case managers neither authorized, nor had any involvement whatsoever in, Full Health's provision of the universal precaution kits at issue.

30. Although Ms. Gonzalez credibly denied having seen any plans of care for the 57 patients who received universal precaution kits from Full Health during the Focal Period, her testimony nevertheless establishes that, more likely than not, the pertinent plans of care failed to identify universal precaution kits specifically as an authorized service. This crucial fact may be (and has been) reasonably inferred from Ms. Gonzalez's unequivocal and unambiguous testimony that none of the case managers involved had authorized any of the universal precaution kits that were delivered during the Focal Period, and none had sent Full Health a service authorization approving the provision of universal precaution kits.[5]

31. The relevant plans of care (Respondent's Exhibits 13 through 69)[6] corroborate Ms. Gonzalez's testimony that the case managers were not involved with, and did not authorize, the provision of universal precaution kits during the Focal Period.

To the point, these documents—in which universal precaution kits are not specifically identified—supplement Ms. Gonzalez's testimony, in the sense of completing the picture that she herself had painted rather vividly; and, moreover, they confirm the accuracy of her perception and the acuity of her recollection of the historical facts. But, it must be stressed, the finding in the immediately preceding paragraph was not based on Respondent's Exhibits 13 through 69; the fact-finder could have and would have made the same finding without these documents, which have been considered as secondary evidence only—and then largely because to have ignored them completely would have violated the evidentiary principles that govern administrative proceedings.[7]

Ultimate Factual Determinations

32. The greater weight of evidence establishes—indeed, it is undisputed—that the universal precaution kits at issue were routinely furnished by Full Health in conjunction with home health aide visits.[8] Moreover, Rule 59G-8.200(2)(h), Florida Administrative Code, affirmatively and unambiguously places such routinely furnished items outside the boundaries which delimit "consumable medical supplies." Thus, as a matter of fact, the universal precaution kits at issue are not Medicaid-compensable "consumable medical supplies" as the rule defines that term.

33. Additionally, a preponderance of evidence demonstrates that none of the universal precaution kits that Full Health furnished to 57 patients during the Focal Period was specified in any patient's plan of care for the Focal Period. Therefore, the entire $193,232.50 that Medicaid indisputably paid to Full Health in reimbursement for these universal precaution kits was an "overpayment" as defined in Section 409.913(1)(d), Florida Statutes. This amount is subject to recoupment. See Rule 59G-8.200(6)(g), Florida Administrative Code.

CONCLUSIONS OF LAW

34. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

35. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on the Agency. South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

36. Although the Agency bears the ultimate burden of persuasion and thus must present a prima facie case (i.e. create a genuine issue of fact as to each essential element of the dispute) through the introduction of competent substantial evidence before the provider is required to respond, the

legislature has lightened the Agency's load considerably. Section 409.913(21), Florida Statutes, provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, the Agency can make a prima facie case without doing any heavy lifting: it need only proffer a properly-supported audit report, which must be received in evidence. See Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, DOAH Case No. 97-3791, 1998 WL 870139, *2 (Recommended Order issued Mar. 20, 1998).

37. The same statute also heightens the provider's duty of producing evidence to meet the Agency's prima facie case. It states:

> A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

Section 409.913(21), Florida Statutes. In other words, once the Agency has put on a prima facie case of overpayment—which may involve no more than moving a properly-supported audit report into evidence—the provider is obligated to come forward with written proof to rebut, impeach, or otherwise undermine the Agency's statutorily-authorized evidence; it cannot simply present witnesses to say that the Agency lacks evidence or is mistaken.[9]

38. Thus, because the ultimate burden of persuasion rests lightly on the Agency, the provider in a typical Medicaid overpayment case refrains at its peril from proffering documentary evidence in support of its position.

39. As set forth in the Findings of Fact above, the trier has determined as matter of ultimate fact that the Agency succeeded in establishing the existence of Medicaid overpayments to Full Health totaling $193,232.50, as alleged. Simply put, there was more than enough evidence to prove that, more likely than not, the universal precaution kits in question were outside the applicable definition of "consumable medical supplies," and also that, more likely than not, the pertinent plans of care failed to mention the universal precaution kits. Either of these independent grounds is an adequate basis, without the other, for requiring Full Health to repay the amount in controversy.

40. The relevant provisions of the governing statutes, rules, and Handbook (which were cited and, frequently, quoted in the foregoing Findings of Fact) are clear and unambiguous as a

matter of law, capable of being relied upon, and applied to the historical events at hand, without a simultaneous examination of extrinsic evidence or resort to principles of interpretation.

41. Accordingly, some findings of fact, especially those regarding the PAC Waiver program and Medicaid claims processing requirements, were derived primarily from the unambiguous language of Rule 59G-8.200, Florida Administrative Code; the plain provisions of Sections 409.907, 409.908, and 409.913, Florida Statutes; and the clear terms of the Handbook. To the extent these fact findings—particularly those set forth in paragraphs 5 through 25, and in paragraphs 32 through 33—are deemed to constitute or reflect legal conclusions, they are hereby incorporated by reference as if set forth in this Conclusions of Law section of the Recommended Order and adopted as such.

42. Full Health has raised several issues in its defense that the Administrative Law Judge has carefully considered and will briefly discuss below.

The Hearsay Objection

43. Full Health argues that Respondent's Exhibits 13 through 69 (the plans of care) have no probative value and must be ignored because the documents: (a) are hearsay, and the Agency failed to lay a proper foundation to introduce them under any recognized exception to the hearsay rule; (b) do not

supplement or explain other admissible evidence and hence, being inadmissible hearsay, are useless; and (c) in any event, were not adequately authenticated at hearing. (The authenticity issue has been discussed and decided, see note 6, supra, and will not be considered further.)

44. In response, the Agency contends that the plans of care are not hearsay because they were offered not to prove the truth of any matters asserted in them but rather to prove the absence of required written authorization for provision of the universal precaution kits. Further, the Agency claims that Mr. Garcia's testimony—(at hearing, Mr. Garcia recounted how, as an investigator for Medicaid, he had obtained the plans of care from the respective case managers, who are required by law regularly to make and preserve them)—laid a predicate for admission of the documents pursuant to Section 90.803(7), Florida Statutes (hearsay exception for absence of entry in records of regularly conducted activity).

45. In discussing the use of business records to prove that an event did not occur, Professor Ehrhardt points out that

> [t]echnically, evidence of the absence of a record is not hearsay under section 90.801. The record is not being offered to prove the truth of any fact contained in the record but rather is being offered as a basis of an inference of the fact of non-occurrence. However, to make certain that there would be no dispute as to the admissibility of a business record to prove the non-occurrence

> of an event, section 90.803(7) was included in the Code.

Ehrhardt, Florida Evidence Section 803.7 (2001 Edition)(footnote omitted). Continuing, Professor Ehrhardt instructs that

> [i]n order to provide for admissibility of evidence under section 90.803(7) it must be shown that the records were kept in accordance with section 90.803(6) [the business records exception] and in such a manner that the fact would have been recorded if it had occurred. It is necessary to call a witness to testify to the required foundation.

Id. (footnote omitted).

46. At first blush the absence-of-entry exception seems to be implicated here. But further reflection reveals otherwise. For, unlike the situation that Section 90.803(7), Florida Statutes, was meant to cover, the relevant fact here, as to each plan of care, is the absent entry itself, not some non-event that might be inferred therefrom. Consider this: If, for whatever reasons, the case managers did not specifically identify universal precaution kits in the plans of care prepared for the Focal Period, then—no inference necessary here—a condition of compensability simply has not been met. In short, the documents in question are not circumstantial evidence of the fact to be proved—namely, whether universal precaution kits were specified in the plans of care—but direct evidence of the dispositive fact.

47. Going a step further, the evidential value of the plans of care lies not in the "truth" of any matters asserted in them but merely in whether universal precaution kits are mentioned therein. That fact is relevant because the law attaches consequences to the descriptions—or lack thereof—of HCB services in PAC Waiver plans of care. The veracity of the out-of-court declarants (the case managers) is irrelevant; all that really matters is whether they wrote "universal precaution kits" on the plans of care. Thus, the plans of care are relevant for the nonhearsay purpose of establishing which services were listed and which were not. See McCormick on Evidence Section 249 (Third Edition); cf. National Labor Relations Board v. H. Koch & Sons, 578 F.2d 1287, 1290-91 (9th Cir. 1978)(oral statements constituting offer and acceptance are not hearsay when offered to prove that contract was made).

48. As evidence that universal precaution kits were not among the specifically listed services, the plans of care are not hearsay. This legal conclusion is not outcome determinative, however, because Respondent's Exhibits 13 through 69 are cumulative evidence of the dispositive point. As explained previously, the plans of care supplement and corroborate Ms. Gonzalez's testimony, the admissibility of which is unassailable.

49. Therefore, even if the documents would have been inadmissible in a civil action, they are nevertheless admissible and useful in this administrative proceeding as secondary proof, to supplement other competent substantial evidence that forms the primary basis of fact findings. Section 120.57(1)(c), Florida Statutes. Recognizing this, and being mindful of the genuine dispute over the admissibility of the plans of care, the trier of fact treated Respondent's Exhibits 13 through 69 as if they were, at best, secondary evidence. No fact findings were based exclusively, primarily, or necessarily on the plans of care.

50. Before leaving the subject of hearsay, a final observation: In view of Section 409.913(21), Florida Statutes, the onus of introducing the plans of care probably belonged to Full Health. The Agency had made a prima facie case without them. It was thus up to Full Health to come forward with documentary evidence—in this case, the plans of care—showing that the universal precaution kits had been specifically listed. Indeed, one might reasonably have expected that, rather than trying to keep the plans of care out, Full Health would have been trying to put them in evidence, regardless of which party had the burden, since its right of reimbursement (assuming Full Health were entitled to reimbursement) depended on them. That it urged exclusion is somewhat revealing.

The Alleged Discovery Misconduct

51. Full Health contends that Respondent's Exhibits 13 through 69 should be excluded on the separate ground that, after having referred the instant matter to the Division of Administrative Hearings, the Agency obtained these plans of care—for which it allegedly had no legitimate investigatory purpose—from the case managers in its capacity as regulator of the Medicaid Program, rather than through formal discovery as a party litigant. In support of this argument, Full Health relies upon Conval Care, Inc. v. Agency for Health Care Administration, 647 So. 2d 300 (Fla. 1st DCA 1994).

52. In Conval, the First District Court of Appeal held that the Agency could not impose an administrative fine against a provider pursuant to Section 409.913, Florida Statutes, for refusing to produce Medicaid-related records upon the Agency's demand during the pendency of a recoupment action, where the Agency lacked a legitimate investigatory purpose for obtaining the Medicaid documents. Id. at 301. The Agency should have sought the documents, said the court, with a request for production, like any other litigant. Id.

53. The Conval decision is distinguishable for the obvious reason that the Agency has not sought to sanction Full Health for failure to furnish Medicaid records. Further, in reversing the final order under review in Conval, which imposed a $5,000

fine against the provider, the court did not decide, either expressly or by necessary implication, that the records would have been inadmissible in the recoupment case had the provider acceded to the Agency's improper demand—and it certainly gave no hint that a non-party's Medicaid-related records would be subject to exclusion if obtained under the Agency's demand power in the absence of a legitimate investigatory purpose.

54. But these distinctions are largely academic, for Conval has been superceded by statute. In 1996, the legislature inserted the following language into Section 409.913(8), Florida Statutes: "The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider." See Chapter 96-387, Section 4, Laws of Florida. In the face of this plain statutory directive, Conval is no longer good law.

55. Accordingly, Full Health has failed to articulate or to prove any persuasive basis in law or fact for excluding Respondent's Exhibits 13 through 69.

The Purported Estoppel

56. Finally, Full Health asserts that the Agency is estopped from seeking recoupment, on the authority of Fraga v. Department of Health and Rehabilitative Services, 464 So. 2d 144 (Fla. 3d DCA), pet. rev. denied, 475 So. 2d 694 (1985). In

Fraga, a divided panel of the Third District Court of Appeal reversed a final agency order directing a psychiatrist (Dr. Fraga) to reimburse the Department of Health and Rehabilitative Service ("HRS") for claims that did not meet then-existing Medicaid requirements, holding that HRS was estopped to pursue recoupment.

57. The estoppel in that case arose from the following facts. Dr. Fraga was not a Board-certified psychiatrist, but he was eligible, upon becoming licensed in 1973 to practice medicine in Florida, to bill Medicaid for psychiatric services. And so he did, without incident, during the period from 1974 through 1979. On January 1, 1980, however, Dr. Fraga suddenly became ineligible for Medicaid reimbursement under a new administrative rule that restricted Medicaid payments for psychiatric services to Board-certified doctors. Id. at 144-45.

58. Immediately after receiving notice of the new rule, in February 1980, Dr. Fraga sent a letter to HRS asking whether he should continue to treat his Medicaid-eligible patients. HRS did not respond to this correspondence, but it did continue to pay the Medicaid claims that Dr. Fraga continued routinely to submit. In August 1981, HRS mailed Dr. Fraga a form letter which told him, misleadingly, that the requirement of Board certification applied only to new providers. Plainly, if this representation were true, then Dr. Fraga would have remained

eligible to receive Medicaid payments. He again wrote a letter to HRS seeking clarification, and again HRS failed to respond. Id. at 147. When HRS finally did reply, in March 1982, it was to make demand on Dr. Fraga for reimbursement of all Medicaid payments for services rendered between January 1, 1980, and March 1982. Id. at 145.

59. Based on these facts, the court accused HRS of "bureaucratic ineptitude and indifference," said the agency "richly deserve[d]" "censure," and held:

> It seems clear that these acts of callous non-responsiveness, longstanding and unprotesting payment, and affirmative misleading should estop the state from asserting, as it first did in March, 1982, that it had been wrong all along, and that Dr. Fraga is required to provide and it and its clients are entitled to receive . . . concededly competent services for nothing.

Id. 147.

60. Full Health claims that the Agency should likewise be estopped because in March 2000 the Agency conducted a routine licensure survey of Full Health's facility pursuant to Section 400.484, Florida Statutes, and was given unrestricted access to Full Health's records, thereby putting the Agency on actual or constructive notice of all Full Health's practices in relation to universal precaution kits. Despite the knowledge acquired through this and previous periodic licensure surveys, Full Health's argument proceeds, the Agency not only failed to object

to Full Health's automatic provision of universal precaution kits but also continued to pay Full Health's Medicaid claims. Full Health complains, additionally, that Agency employees misinformed Full Health regarding the types of Medicaid-related records required to be kept in the provider's files.

61. These circumstances do not a case of Fraga-estoppel make. Indeed, Fraga is wholly inapposite. Unlike Dr. Fraga, Full Health did not encounter a recent change in the law that suddenly rendered formerly compensable services ineligible for Medicaid reimbursement. Unlike Dr. Fraga, Full Health never sent the Agency a written request for guidance, never asked whether it could be reimbursed for routinely-provided universal precaution kits that were not listed in the patients' plans of care. And unlike HRS, the Agency was not shown to have made any affirmative, material misrepresentations to Full Health. In sum, the evidence in this case falls far short of establishing "callous non-responsiveness, longstanding and unprotesting payment, and affirmative misleading."

62. It should be understood, too, that the Fraga decision stands as an exception to the general rule that "equitable estoppel will be applied against the state only in rare instances and under exceptional circumstances." State Department of Revenue v. Anderson, 403 So. 2d 397, 400 (Fla. 1981)(emphasis added). As such, Fraga must be strictly limited

to its singular facts. See Lewis v. State Department of Health and Rehabilitative Services, 659 So. 2d 1255, 1257 (Fla. 4th DCA 1995). The situation here being neither rare nor exceptional, the Agency is not estopped.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order requiring Full Health to repay the Agency the principal amount of $193,232.50.

DONE AND ENTERED this 25th day of June, 2001, in Tallahassee, Leon County, Florida.

JOHN G. VAN LANINGHAM
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 25th day of June, 2001.

ENDNOTES

1/ Some knowledge of the PAC Waiver program is required to appreciate the relevance of the historical facts remaining to be discussed. To the extent this sections tells of the law, the perspective is that of the fact-finder, who needed to know something of (and was presented evidence concerning) the legal environment in which the actors were operating.

[2]/ Section 409.908, Florida Statutes, provides that, "[s]ubject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein." (Emphasis added). In view of this mandate, the Agency would be well advised (if it is not legally required) to adopt the Handbook as a rule through an incorporating reference in the Florida Administrative Code, as it has done in other instances. See, e.g., Rule 59G-8.200(15)(incorporating, by reference, the Florida Medicaid Assisted Living for the Elderly Waiver Coverage and Limitations Handbook). It is possible, of course, that the Medicaid provider agreement between the Agency and Full Health specifically obligates Full Health to comply with the Handbook. See Section 409.907, Florida Statutes. Unfortunately, however, the pertinent provider agreement was not introduced in evidence.

[3]/ If the Handbook were ignored, the outcome of this case would be the same, because the dispositive principles are found in the Agency's rules. See Rule 59G-8.200(6)(g), Florida Administrative Code ("Reimbursement claims for the provision of Medicaid services not listed in the plan of care of HCB services waiver program participants are subject to denial or recoupment."), and Rule 59G-2-800(2)(h)(defining the term "consumable medical supplies").

[4]/ All citations to the Handbook refer to the April 1999 version in evidence as Petitioner's Exhibit 1.

[5]/ To find otherwise, consistent with Ms. Gonzalez's testimony, would require a belief that all (or at least some) of the case managers involved, following the proper procedures, initially had approved universal precaution kits in their respective clients' plans of care and then, to a person, inexplicably had failed to obey the rule-based requirement of transmitting written service authorizations to Full Health—or even to notify Full Health verbally of such approval. The trier of fact rejects this notion as far-fetched and incredible—especially in view of Ms. Gonzalez's testimony, which is accepted as truthful, that every other service that Full Health provided to PAC Waiver patients during the Focal Period was the subject of a written service authorization.

Further, the undisputed amount in controversy—$193,232.50—makes it extraordinarily unlikely that any of the case managers would have authorized plans of care that specified the provision of universal precaution kits and then failed to notify Full Health of that fact. Consider that, even if Full Health is given the generous benefit of an assumption that all 57 of the affected patients received universal precaution kits from Full Health during each of the six months comprising the Focal Period, making a total of 342 patient-months (57 x 6 = 342), the average cost of universal precaution kits per patient, per month, is $565 (193,232.50 ÷ 342 = 565). Because a case manager's discretionary approval authority is capped at $2,000 per month, per patient, the odds are small that he or she would approve such a significant expenditure (28% of the monthly dollars-per-patient limit) and thereafter fail to properly implement the authorized service with a written service authorization; the odds that all of the case managers involved would consistently fail to do so—for this one service only, no less—are practically nil.

[6]/ At hearing, the Administrative Law Judge determined as a matter of law that the Agency had made a prima facie showing that Respondent's Exhibits 13 through 69 were authentic. The trier has concluded, and so finds, that these documents are in fact genuine—that is, they are the plans of care that the Agency claims them to be. See Garcia v. State, 564 So. 2d 124, 126 (Fla. 1990).

[7]/ See Bellsouth Advertising and Publishing Corp. v. Unemployment Appeals Commission, 654 So. 2d 292, 294 (Fla. 5th DCA 1995)(hearing officer committed reversible error by ignoring hearsay that supplemented other admissible nonhearsay evidence). The Administrative Law Judge has concluded that Respondent's Exhibits 13 through 69 are not hearsay but, in an abundance of caution, treated them as if they were. See paragraphs 43-50, infra.

[8]/ In its proposed recommended order, Full Health urged the adoption of the following as fact: "Mayelin Gonzalez, an officer of Full Health, testified that, based on her six years in the home health business, these supplies (universal precaution kits) are routinely provided pursuant to standing physician orders received directly from the patients' physicians and that the provision of those supplies is standard infection protocol with respect to AIDS patients under the PAC Waiver program." Pet. Rec. Order at 12 (emphasis added). This statement is essentially accurate and is consistent with the findings set forth in the text. Logically, items that are

routinely furnished, as these universal precaution kits were, cannot also be considered "in excess of those routinely furnished," as the rule defining "consumable medical supplies" plainly requires.

9/ Theoretically, a provider might advance so compelling an argument as to convince the fact-finder to disbelieve the Agency's audit report (assuming the Agency had rested on that evidence alone) and thereby defeat the Agency's recoupment effort without offering any evidence. In that situation, the Agency would lose, not because it had failed to make a prima facie case (the audit report being enough evidence to carry the Agency across the threshold of legal sufficiency), but because it had failed to persuade the trier of fact that the evidence established the probable truth of the Agency's allegations. As a practical matter, however, such an outcome is unlikely.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.