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AHCA
AGENCY CLERK
2018 JUN 25 A 10: 17

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SOUTH MIAMI HOSPITAL, INC.,

Respondent.
_____ /

DOAH CASE NO.: 14-2795MPI
MPI CASE NO.: 2015-0002855
C.I. NO.: 12-2276-000
PROVIDER NO.: 010058700
NPI NO.: 1982688230
LICENSE NO.: 4033
PETITION NO.: AHCA-18-0391-S-MDD

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a Settlement Agreement. The parties are directed to comply with the terms of the attached settlement agreement. Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 25 day of June, 2018, in Tallahassee, Florida.

JUSTIN M. SENIOR, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS 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 RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

South Miami Hospital, Inc.
P.O. Box 402038
Atlanta, GA 30384
(U.S. mail)

Craig H. Smith
Hogan Lovells US LLP
600 Brickell Avenue
Suite 2700
Miami, Florida 33131
E-Mail: craig.smith@hoganlovells.com
(E-Mail)

Joseph M. Goldstein, Esquire
Shutts & Bowen LLP
200 East Broward Blvd., Suite 2100
Fort Lauderdale, FL 33301
jgoldstein@shutts.com
(E-Mail)

Division of Health Quality Assurance
Bureau of Health Facility Regulation
(E-Mail)

Shena L. Grantham, Esquire
MAL & MPI Chief Counsel
Shena.Grantham@ahca.myflorida.com
(E-Mail)

Division of Health Quality Assurance
Bureau of Central Services
CMSU-86@ahca.myflorida.com
(E-Mail)

Kelly Bennett, Chief, MPI
(Interoffice mail)

Bureau of Financial Services
(Interoffice mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail or other designated method on this the 25 day of June, 2018.

Richard J. Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3689/FAX (850) 921-0158

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SOUTH MIAMI HOSPITAL, INC.,

Respondent.
_____ /

DOAH CASE NO.: 14-2795MPI
MPI CASE NO.: 2015-0002855
C.I. NO.: 12-2276-000
PROVIDER NO.: 010058700
NPI NO.: 1982688230
LICENSE NO.: 4033

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION** ("AHCA" or "Agency"), and Respondent, **SOUTH MIAMI HOSPITAL, INC.,** provider number 010058700, ("PROVIDER"), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties agree to settle DOAH Case No. 14-2795MPI (this matter) wherein Provider filed a petition for a formal administrative hearing regarding the Final Audit Report issued by AHCA on August 12, 2013.

2. PROVIDER is a Medicaid provider in the State of Florida, provider number 010058700, and was a provider during the audit period.

3. A preliminary audit report dated November 9, 2012, was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid $152,398.71. On August 12, 2013, a Final Audit Report was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid $148,352.47.

4. In its Final Audit Report, the Agency notified PROVIDER that a review performed by the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity ("MPI") of PROVIDER'S Medicaid claims that were rendered during the period of January 1, 2008, through December 31, 2008, indicated that certain claims, in whole or in part, were inappropriately paid by AHCA. The Agency sought total repayment of this alleged overpayment, in the amount of one hundred forty-eight thousand three hundred fifty-two dollars and forty-seven cents ($148,352.47).

5. In response to the Final Audit Report dated August 12, 2013, PROVIDER timely filed a *Petition for Formal Administrative Hearing.* Under protest, PROVIDER also refunded to AHCA $148,352.47 pending the outcome of its administrative challenge to AHCA's determination.

6. In order to resolve this matter without further administrative proceedings, and based upon additional information received and reviewed by AHCA during the pendency of litigation, PROVIDER and AHCA agree as follows:

A. AHCA agrees to accept the payment set forth herein in full settlement of the amounts arising from the above-referenced audit.

B. AHCA and PROVIDER agree to settle this matter for the sum of one hundred eleven thousand three hundred thirty-eight dollars and nineteen cents ($111,338.19), which includes an amount of one hundred eleven thousand two hundred sixty-four dollars and thirty-five cents ($111,264.35) attributable to the alleged overpayment and costs of seventy-three dollars and eighty-four cents ($73.84).

C. Following AHCA's entry of the Final Order adopting this Settlement Agreement, AHCA shall refund to PROVIDER $37,014.28. PROVIDER shall be refunded this amount of $37,014.28 as follows:

a. Within thirty (30) days following the issuance of a Final Order in this case, Financial Services shall forward the Provider a Refund Application reflecting the refund due to the PROVIDER;

b. Once Financial Services has received the signed Refund Application, the refund will be processed.

c. Payment of the refund shall be made within thirty (30) day of Financial Services receipt of the signed Refund Application.

D. PROVIDER and AHCA agree that full payment, as set forth above, and already made, resolves and settles this case completely and releases both parties from any administrative or civil liabilities arising from the review determinations relating to the claims as referenced in audit C.I. No: 12-2276-000.

E. PROVIDER agrees that it shall not re-bill the Medicaid Program in any manner for the claims that are the subject of the review in this case as specifically identified in the Final Audit Report.

7. AHCA and PROVIDER each reserve the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

8. This settlement does not constitute a finding or an admission of wrongdoing or

error by either party with respect to this case or any other matter. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

9. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Leon County, Florida.

10. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with or employed by them, concerning this matter and supersedes any prior discussions, agreements or understandings regarding this matter; there are no promises, representations or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

11. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information and contentions as to facts and law, and with each party compromising and settling any potential correctness or incorrectness of its understandings, information and contentions as to facts and law, so that no misunderstanding or misinformation shall be a ground for rescission hereof.

12. PROVIDER expressly waives its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes, the making of findings of fact and conclusions of law by the Agency, and all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this matter. PROVIDER further agrees that it shall not challenge or contest any Final Order entered in this matter that is consistent with the terms of this Agreement in any forum now or in the future available to it, including the right to any administrative proceeding, circuit or federal court action or any appeal.

13. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses and expenses, of any and every nature whatsoever, arising in this matter, AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this Agreement; provided, however, PROVIDER does not discharge the State of Florida, Agency for Health Care Administration, regarding any other matters related to AHCA's payments, practices, policies or audits of services rendered to undocumented aliens.

14. The parties agree to bear their own attorney's fees and costs, if any, with the exception that PROVIDER shall reimburse, as part of this settlement, costs of $73.84. This amount is included in the calculations and demand of paragraph 6(B).

15. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

16. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement; provided, however, if the entitlement to a refund to PROVIDER in paragraph 6 is prohibited, or if a Final Order has not been issued within 180 days from the date of signature by PROVIDER, PROVIDER shall have the right to void this Agreement.

17. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.

18. All times stated herein are of the essence of this Agreement.

19. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

SOUTH MIAMI HOSPITAL, INC.

Lincoln S. Mendez
(Signed)

Dated: June 12, 2018

BY: Lincoln Mendez, CEO
(Print Name and Title)

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403

Molly McKinstry
Deputy Secretary for HQA

Dated: 6/25, 2018

Stefan R. Grow, Esquire
General Counsel

Dated: 6/19, 2018

Shena L. Grantham, Esquire
Medicaid Admin. Lit. and MPI Chief Counsel

Dated: 6/19, 2018

Joseph M. Goldstein, Esquire
Shutts & Bowen LLP

Dated: June 14, 2018

FTLDOCS 7422528 1

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL No.: 7009 2820 0001 5672 8599

August 12, 2013

EXHIBIT 1

Provider No.: 010058700
NPI No.: 1982688230
License No.: 4033

South Miami Hospital, Inc.
Attn: Lincoln Mendez, Chief Executive Officer
Executive Office
6200 SW 73rd St.
Miami, FL 33143

In Reply Refer to
FINAL AUDIT REPORT
C.I.: No. 12-2276-000

Dear Provider:

Enclosed is the Final Audit Report for South Miami Hospital, Medicaid provider number 010058700. The audit was conducted by Health Integrity, LLC, on behalf of Centers for Medicaid and Medicare Services and the State of Florida Agency for Health Care Administration, Office of the Inspector General, Bureau of Medicaid Program Integrity. The audit covered claims paid during the period January 1, 2008 through December 31, 2008 for emergency services provided to aliens. You previously received a preliminary draft audit report dated November 9, 2012 indicating that you were overpaid $152,398.71. Based upon the final audit review, it is determined that you were overpaid $148,352.47 for services that in part or in whole were not covered by Medicaid.

Findings were made in accordance with the provisions of federal and state law, Florida Medicaid Provider General Handbook, Florida Medicaid Hospital Services Coverage and Limitations Handbook and Medicaid Provider Reimbursement Handbook. Definitions for Emergency Medical Condition, Emergency Services and Care, Medical Necessary or Medical Necessity, may be found in the Florida Medicaid Provider General Handbook. Other relevant references may be found in the Florida Administrative Code, Florida Statutes and in federal law. Pursuant to Section 409.913(23) (a) F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs. Costs have been applied in the amount of $73.84.

If you are currently involved in a bankruptcy, you should notify your attorney immediately and provide a copy of this letter to them. Please advise your attorney that we need the following information immediately: (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division); and, (4) the name, address, and telephone number of your attorney. If you are not in bankruptcy and you concur with our findings, please remit payment by certified check in the amount of $148,426.31, which includes the overpayment amount as well as assessed costs. The check must be payable to the **Florida Agency for Health Care Administration.**

Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report.
Please mail payment to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program. Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (**21**) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the enclosed Notice of Administrative Hearing and Mediation Rights.**

Any questions you may have about this matter should be directed to: **Tracy MacDonell**, AHCA Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone: 850-412-4600, facsimile: (850) 410-1972, email: macdonet@ahca.myflorida.com.

Sincerely,

Johnnie L. Shepherd
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity

JS/tm/cml

Enclosure(s):
Notice of Administrative Hearing and Mediation Rights
Provider Overpayment Remittance Voucher
Final Audit Report
Spreadsheet of Findings
Provider Response to Preliminary Draft Audit Report
Medical Peer Review(s)

Copies furnished to:

Finance & Accounting
(Interoffice mail)

Health Quality Assurance
(E-mail)

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration, by 5:00 P.M. no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158
Phone: (850) 412-3630

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.

FAR

Provider Overpayment Remittance Voucher

If you choose to make payment, please return this form along with your check.

Complete this form and send along with your check to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

CHECK MUST BE MADE PAYABLE TO: FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Provider Name:	South Miami Hospital, Inc.
Provider ID:	010058700
MPI Case #:	12-2276-000
Overpayment Amount:	$148,352.47
Costs:	$73.84
Total Due:	$148,426.31
Check Number:	#_____

A final order will be issued that will include the final identified overpayment, applied Sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter.

Payment for Medicaid Program Integrity Audit

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

South Miami Hospital, Inc.
Attn: Lincoln Mendez, Chief Executive Officer
Executive Office
6200 SW 73rd St.
Miami, FL 33143
C.I.#: 12-2276-000/TM/cml/CMSFAR

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

e
Mail ☐ Express Mail
ed ☐ Return Receipt for Merchandise
Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7009 2820 0001 5672 8599

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

EXHIBIT 2

UNITED STATES POSTAL SERVICE

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G

RECEIVED
AUG 26 2013
Medicaid Program Integrity

Agency for Health Care Administration
Medicaid Program Integrity
2727 MAHAN DRIVE, MAIL STOP #6
TALLAHASSEE, FLORIDA 32308
Institutional Unit