STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

PLAYBIG THERAPY AND RECREATION ZONE, LLC; KELLEY H. HUTTO, P.T.; AND RACHEL SCHARLEPP,

Petitioners,

vs. Case No. 16-3972F

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

PARTIAL FINAL ORDER

Pursuant to notice, a final hearing was held in this case on November 10, 2016, in Tallahassee, Florida, before Garnett W. Chisenhall, a duly-designated Administrative Law Judge of the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: Thomas M. Findley, Esquire
William P. Dillon, Esquire
Ellery W. Sedgwick, Esquire
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For Respondent: Joseph G. Hern Jr., Esquire
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STATEMENT OF THE ISSUE

The issue to be determined is whether PlayBig Therapy and Recreation Zone, LLC; Kelley H. Hutto, P.T.; and Rachel Scharlepp (collectively referred to as "Petitioners") are entitled to an award of attorney's fees and costs pursuant to section 57.111, Florida Statutes (2015).[1/] Petitioners are entitled to such an award if: (a) Petitioners were the prevailing parties in a previous administrative proceeding initiated by the Agency for Health Care Administration ("AHCA"); (b) AHCA's actions were not substantially justified; and (c) no special circumstances exist that would make an award of fees and costs unjust.

PRELIMINARY STATEMENT

On July 11, 2016, Petitioners filed a "Petition and Application for Attorneys' Fees" asserting they were entitled to an award of fees and costs pursuant to section 57.111. In support thereof, Petitioners argued that AHCA lacked substantial justification when it: (a) suspended Petitioners' Medicaid payments; (b) denied Petitioners' request for a good cause exception to the suspension; and (c) opposed Petitioners' request for a formal administrative hearing.

On July 27, 2016, AHCA filed a "Motion to Dismiss Petition and Application for Attorney's Fees" (the "Motion to Dismiss") arguing that, as a matter of law, Petitioners could not satisfy

certain requirements for an award of fees pursuant to section 57.111. After considering Petitioners' response, the undersigned issued an Order on August 4, 2016, denying the Motion to Dismiss.

On August 16, 2016, AHCA filed a Motion for Summary Final Order arguing that there were no material facts in dispute. However, the undersigned issued an Order on September 12, 2016, stating:

> [T]he undersigned is not persuaded that there are no material facts in dispute. In particular, there appear to be material facts in dispute as to whether Petitioners were prevailing parties and whether Respondent's actions were substantially justified within the meaning of section 57.111, Florida Statutes. See § 120.57(1)(i), Fla. Stat. (providing that "[a]n order relinquishing jurisdiction shall be rendered if the Administrative Law Judge determines from the pleadings, depositions, answers to interrogatories, and admissions on file, together with supporting and opposing affidavits, if any, that no genuine issue as to any material fact exists.").

Prior to the final hearing in this matter, a dispute arose over whether Petitioners could discover documents and/or information pertaining to a criminal investigation of their Medicaid billings. AHCA filed a Motion for Protective Order on August 19, 2016, asserting that disclosure "of that information would prejudice the criminal investigation of Petitioners and

constitute a violation of law and could subject AHCA personnel to criminal prosecution."

After considering Petitioners' Response to the Motion for Protective Order and argument from the parties during a telephonic motion hearing on September 8, 2016, the undersigned granted AHCA's Motion for Protective Order via an Order issued on September 12, 2016. Nevertheless, the undersigned recognized Petitioners' valid concern that the criminal investigation could end immediately prior to the November 18, 2016, final hearing and that AHCA could attempt to introduce information from that investigation into evidence without Petitioners having an adequate opportunity to conduct discovery and/or prepare a defense. Accordingly, the undersigned specified in the aforementioned Order that "Petitioners may file a motion in limine if [AHCA] continues to maintain after October 18, 2016, that the information at issue is not subject to disclosure."

On September 12, 2016, the undersigned issued an Order granting Petitioners' request to officially recognize the dockets in DOAH Case Nos. 16-2604MPI, 16-2605MPI, and 16-2606MPI. The proceedings in those cases will be discussed in the foregoing Findings of Fact.

The undersigned also issued an Order of Bifurcation on September 12, 2016, specifying that:

> The final hearing scheduled for November 18, 2016, shall be limited to accepting evidence and testimony regarding the following subjects: (1) whether Petitioners were "prevailing small business parties" in the underlying proceeding; and whether (2) Respondent's actions in the underlying proceeding were "substantially justified." If necessary, the undersigned will schedule a second hearing to address the reasonableness of the attorney's fees and costs sought by Petitioners.

In response to a "Motion to Reschedule Final Hearing" filed by AHCA on September 13, 2016, the undersigned issued an Order on September 15, 2016, re-scheduling the final hearing for November 10, 2016.

On October 21, 2016, and as authorized by the Order granting AHCA's Motion for Protective Order, Petitioners filed a Motion in Limine to preclude AHCA from seeking to introduce any documentation into evidence that had not already been disclosed to Petitioners through discovery. Petitioners also sought to preclude AHCA from introducing any documentation reflecting information unavailable to AHCA on April 14 and 15, 2016, the dates when AHCA suspended Petitioner's Medicaid payments.

An Order issued on November 8, 2016, partially granting and partially denying Petitioners' Motion in Limine:

> With regard to Petitioners' request that AHCA be prohibited from introducing any evidence that was not disclosed to Petitioners by October 18, 2016, the Motion in Limine states that Petitioners received discovery from AHCA on October 18, 2016,

pertaining to Petitioners' Request for Production. Because the final hearing in this matter is scheduled to occur on November 10, 2016, Petitioners would likely be prejudiced if the undersigned were to consider any evidence that has not already been disclosed to Petitioners through discovery. Accordingly, the undersigned concludes that this request is well-taken and grants Petitioners' request that AHCA be prohibited from introducing at the final hearing any evidence that was not disclosed by October 18, 2016.

Petitioners also seek to prohibit AHCA from introducing at the final hearing any documents reflecting information that was unavailable to AHCA on April 14 and 15, 2016. In support thereof, Petitioners note that the substantial justification defense against an award of fees pursuant to section 57.111 must be based on information available to the agency when the action at issue was taken. See § 57.111(4)(a), Fla. Stat. (providing that "an award of attorney's fees and costs shall be made to a prevailing small business party in any adjudicatory proceeding or administrative proceeding pursuant to chapter 120 initiated by a state agency, unless the actions of the agency were substantially justified or special circumstances exist which would make an award unjust."); McCloskey v. Dep't of Fin. Servs., 172 So. 3d 973, 976 (Fla. 5th DCA 2015)(noting that "[s]ubstantial justification must exist at the time the agency initiates the action as '[s]ubsequent discoveries do not vitiate the reasonableness of the actions of the [agency] at the time they made their probable cause determinations.'")(quoting Dep't of Health v. Cralle, 852 So. 2d 930, 933 (Fla. 1st DCA 2003)). AHCA responds to this request by asserting that it will also be asserting the "special circumstances" defense available under section 57.111(4)(a) and that information available to AHCA after

April 14 and 15, 2016, is relevant to that defense.

There is very little authority addressing the special circumstances defense. However, in RHC Associates, Inc. v. Hillsborough County School Board, Case No. 02-3922F, 2003 Fla. Div. Admin. Hear. LEXIS 309 (Fla. DOAH Feb. 3, 2002), the Honorable T. Kent Wetherell, II noted that section 57.111 was patterned after the federal Equal Access to Justice Act, 5 U.S.C.A. § 504. The federal statute also provides for a special circumstances defense. After reviewing federal case law construing that defense, ALJ Wetherell concluded that

> Unlike the substantial justification defense which, by virtue of Section 57.111(3)(e), is limited to circumstances in existence "at the time [the proceeding] was initiated by the state agency," the special circumstances defense is grounded in equity and therefore appears to require a broader view of the circumstances of the proceeding which generated the fee request. Accordingly, in determining whether an award under the FEAJA would be equitable (or "unjust"), all of the circumstances of the DOAH Case No. 02-2230BID, including events subsequent to the initiation of the proceeding such as the School Board's successful defense of its new policies and summaries of procedures in the related DOAH Case No. 02-3138RP, are appropriate to be considered.

RHC Associates, 2003 Fla. Div. Admin. Hear. LEXIS 309, at * 29. See also Air Transp. Ass'n of Can. v. FAA, 156 F.3d 1329, 1333 (D.C. Cir. 1998)(noting that the "theme of 'unclean hands' pervades the

> jurisprudence of 'special circumstances' under EAJA.").

The final hearing was held as scheduled on November 10, 2016. Petitioners presented no witnesses in their case in chief. Instead, Petitioners asserted that the joint exhibits and the officially recognized dockets conclusively established that they (within the meaning of section 57.111) were the prevailing parties and that AHCA initiated the action at issue. Petitioners offered the following Exhibits that were accepted into evidence: 2, 3, 5, 7, 10,[2/] and 11.

AHCA presented the testimony of Tim Helms and Captain Gary Bergert. AHCA Exhibits 1 through 3, 5 through 13, and 16 through 19 were accepted into evidence during the final hearing. The undersigned reserved ruling on the admissibility of AHCA Exhibits 4, 14, and 15, and the admissibility of the aforementioned exhibits is discussed below in the Conclusions of Law.

The Transcript from the final hearing was filed on December 1, 2016. On December 7, 2016, AHCA filed an "Unopposed Motion to Extend Submission Date of Proposed Final Orders." The undersigned issued an Order on December 8, 2016, granting the aforementioned Motion and establishing December 22, 2016, as the deadline for filing the proposed final orders.

The Proposed Final Orders were timely filed by the parties, and the undersigned considered them in the preparation of this Partial Final Order.

FINDINGS OF FACT

Background on the Medicaid Program

1. AHCA is the state agency responsible for managing Florida's Medicaid program and protecting the program's financial integrity. See § 409.913, Fla. Stat. (2016)(providing that AHCA "shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.").

2. "Medicaid is a joint state and federal program providing medical coverage to low-income persons." Bell v. Ag. for Health Care Admin, 768 So. 2d 1203 (Fla. 1st DCA 2000). The federal government pays 50-to-83 percent of the cost a participating state incurs for patient care. In addition to paying its share of the cost for patient care, a participating state complies with certain statutory requirements regarding eligibility determinations and program administration. Ark. Dep't of Health & Human Serv. v. Ahlborn, 547 U.S. 268, 275, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

3. In order to retain federal funding, a participating state must comply with all federal statutes and regulations governing Medicaid. See Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 501, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990).

4. Of particular relevance to the instant case is 42 C.F.R. § 455.23(a)(1) which requires a state Medicaid agency to:

> Suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

(emphasis added). See also 42 C.F.R. § 455.2 (defining "fraud" as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.").

5. As set forth in 42 C.F.R. § 455.2, a "credible allegation of fraud" may:

> [B]e an allegation, which has been verified by the State, from any source, including but not limited to the following:
>
> (1) Fraud hotline complaints.
>
> (2) Claims data mining.
>
> (3) Patterns identified through provider audits, civil false claims cases, and

> law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(emphasis added).

6. An informational bulletin from the Department of Health and Human Services' Centers for Medicare & Medicaid Services issued on March 25, 2011, described what a State should do when it receives an allegation of fraud:

> A State must follow the requirements of 42 C.F.R. § 455.14 which describes preliminary investigations. States must also review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. CMS recognizes that there may be mistaken or false reports of allegations of fraud. Due to the potential for false allegations, CMS encourages States to not solely rely on a singular allegation without considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations.

(emphasis added).

7. A health care provider receives an "overpayment" if that provider receives more money than it is entitled by defrauding the Medicaid program. However, the term "overpayment" also encompasses activities by a Medicaid provider that are not fraudulent. See § 409.913(1)(e), Fla. Stat. (2016)(defining "overpayment" to include "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.").

8. Overpayment cases involving no fraudulent activity are prosecuted administratively by AHCA. See Ady Optical, Inc. v. Ag. for Health Care Admin., Case No. 04-00030MPI (Fla. DOAH May 27, 2004; Fla. AHCA Aug. 4, 2004). In contrast, AHCA refers overpayment cases involving suspected fraudulent activity to the Medicaid Fraud Control Unit ("MFCU") of the Office of the Attorney General. § 409.913(4), Fla. Stat. (2016).

9. If a Medicaid provider's payments have been suspended, 42 C.F.R. § 455.23(a)(3) specifies that "[a] provider may request, and must be granted, administrative review where State law so requires." (emphasis added).

Facts Specific to the Instant Case

10. PlayBig Therapy and Recreation Zone, LLC (referred to individually as "PlayBig"), is a pediatric therapy provider. PlayBig's client base includes Medicaid recipients, and a majority of those clients are autistic children.

11. Kelly Hutto is a licensed physical therapist who owns 51 percent of PlayBig.

12. On March 6, 2014, Kelly Hutto (as the owner of PlayBig Therapy) signed a Medicaid Provider Agreement containing a provision stating that "[t]he provider agrees to comply fully with all state and federal laws, rules, regulations, and

statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by the Agency, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts."

13. On May 20, 2015, Ms. Hutto (in her individual capacity) signed a Non-Institutional Medicaid Provider Agreement containing a provision identical to the one described directly above.

14. Rachel Scharlepp is a licensed clinical social worker who owns 49 percent of PlayBig.

15. On May 6, 2011, Ms. Scharlepp signed a Non-Institutional Medicaid Provider Agreement containing a provision stating that "[t]he provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA."

16. Even though Petitioners are Medicaid providers, AHCA does not directly reimburse them for medically necessary services provided to Medicaid recipients. Instead, Petitioners receive compensation from one or more managed care organizations ("MCOs") that contract with AHCA for the provision of services to Medicaid recipients.

17. One of the services provided by PlayBig is targeted case management or "TCM." TCM is broadly defined as assistance to ensure that someone, especially one lacking a natural support system, such as a family member, is able to fully access health care, social services, and the educational system.

18. MFCU received a complaint that PlayBig was defrauding the Medicaid program by billing for services never rendered and billing for the same service multiple times.

19. The MFCU investigator who received the aforementioned complaint prepared a search warrant for PlayBig's location, and a judge signed the warrant.

20. MFCU executed the search warrant on the morning of April 14, 2016, and seized documents, records, and other items.

21. Gary Bergert is the Northern Regional Captain for MFCU. After MFCU completed the search of PlayBig's location, Captain Bergert and James Varnando, the Director of MFCU, attended a regularly scheduled, bi-weekly meeting at AHCA's headquarters in Tallahassee.

22. AHCA and MFCU typically discuss Medicaid providers suspected of defrauding the program during these bi-weekly meetings.

23. The bi-weekly meeting on April 14, 2016, occurred at 3:00 p.m. and was also attended by Timothy Helms of AHCA and members of his staff.

24. Since April of 2015, Mr. Helms has been the administrator of AHCA's Prevention Strategy Unit, which is responsible for preliminary investigations of Medicaid providers and imposes sanctions such as payment restrictions, suspensions, and termination from the Medicaid program.

25. Director Varnando and Captain Bergert told Mr. Helms about the search warrant executed that morning and that documents were seized.

26. Notes taken by Mr. Helms during the meeting indicate MFCU was alleging that PlayBig was billing for physical therapy, occupational therapy, and behavioral therapy simultaneously.

27. Mr. Helms' notes also indicate that MFCU was alleging that PlayBig was: (a) billing for TCM for Medicaid recipients who lacked the necessary mental health diagnosis; (b) billing for TCM for the family members of Medicaid recipients when the family members lacked the necessary mental health diagnosis; (c) billing for TCM and therapy services at the same time; and (d) billing for services not rendered.

28. Captain Bergert brought no documents to the meeting, he did not discuss specific patients, and there was no discussion of any specific diagnoses. In addition, Captain Bergert did not identify any specific claims that MFCU considered to be fraudulent. Also, Captain Bergert and Director Varnando brought no evidence from the search of PlayBig's

location to the meeting. Captain Bergert testified he could not discuss information of that nature with AHCA because MFCU was engaged in an ongoing investigation of Petitioners.

29. The information provided by Captain Bergert and Director Varnando was nothing more than the allegations described above and lacked anything that would have meaningfully assisted AHCA with verifying that the aforementioned allegations were credible. As testified by Captain Bergert:

> We gave them an overview of what we did of certain things that we found, but I did not give any specifics as to who the patients were, who the provider was that actually caused the fraud at that time. And it was in reference to informing them that a CAF letter would be following that day for payments of the facility.

30. A "CAF letter" refers to a letter from MFCU describing a credible allegation of fraud. At 3:30 on the afternoon of April 14, 2016, Mr. Helms received a CAF letter from Robert S. Peterson, an Assistant Attorney General within MFCU. The CAF letter stated the following:

> Under the provisions of 42 CFR 1007.9(e)(1), we are advising you that the Medicaid Fraud Control Unit (MFCU) is conducting an investigation which has established a credible allegation of fraud under the Medicaid program involving the following provider and provider numbers in TCM cases:

Rachel Lynn Scharlepp
4500 W. Shannon Lakes Drive,
Suite 3, Tallahassee Florida 32309
Case Management Agency
Provider No: 0035914-00

PlayBig Therapy and Recreation
Zone, LLC
4500 W. Shannon Lakes Drive,
Suite 3, Tallahassee Florida 32309
Case Management Agency
Provider No: 0134419-00

This information is referred to you for possible suspension of payments to this provider under 42 CFR 455.23. The MFCU will continue actively investigating this case as a criminal matter.

The credible allegations of fraud include, but are not limited to, (1) a factual finding that this provider billed the Florida Medicaid Program for Targeted Case Management services for clients who did not have the requisite mental health diagnosis at the time such services were claimed to have been provided; and (2) a factual finding that this provider billed for Targeted Case Management services for services never provided.

31. Mr. Helms testified that AHCA did the following after receiving the CAF letter from Assistant Attorney General Peterson:

Well, once we receive that information we begin the process to review the information. We're going to conduct a preliminary investigation, assessing the information to determine, first of all, are there indicia of reliability. We're reviewing the totality of the facts and circumstances that contribute to that indicia, and we are drawing a conclusion based upon our assessment of whether we concurred that

there are, in fact, credible allegations of fraud.

32. AHCA's preliminary investigation did not include any contact with Ms. Hutto or Ms. Scharlepp because AHCA did not want to interfere with MFCU's criminal investigation.

33. AHCA's preliminary investigation primarily focused on information within the Florida Medicaid Management Information System ("FFMIS"), a data warehouse.

34. AHCA found multiple addresses for Petitioners in FFMIS and in the "Sunbiz" website maintained by the Department of State. Also, those addresses differed from the addresses identified by MFCU in the CAF letter.

35. Mr. Helms testified that multiple addresses for a particular provider is concerning because AHCA would not know where to go if it desired to make an unannounced site visit to a provider's place of business.

36. There is nothing fraudulent about a provider not using a single address for official purposes. Mr. Helms did not identify any statutes or rules that would be violated if a provider utilized multiple addresses for official purposes.

37. AHCA also found during its preliminary investigation that Petitioners had four Medicaid provider numbers in addition to the two noted by MFCU in the CAF letter.

38. Mr. Helms testified that a Medicaid provider with multiple provider numbers is concerning because if a payment restriction were to be imposed on one provider number, then the provider could circumvent the payment restriction by billing Medicaid through one of its other provider numbers.

39. There is nothing fraudulent about a provider having more than one provider number. Mr. Helms did not identify any statutes or rules that would be violated if a provider had multiple Medicaid provider numbers.

40. AHCA's preliminary investigation also determined that Petitioners' billings were through an unexpected type of provider number. For example, a Medicaid provider furnishing occupational, physical, speech, and/or respiratory therapies would have a provider type 83. A case management agency would bill for TCM through a provider type 91.

41. None of Petitioners' TCM claims were billed through a provider type 91. Instead, all of Petitioners' claims were billed under provider type 83.

42. Billing Medicaid through an incorrect provider type number is not fraudulent.

43. While Mr. Helms and his staff reviewed the information in FFMIS, there is no testimony about how that review actually led to the verification of the allegations presented by MFCU on April 14, 2016.[3/] For example, in response to a question about

whether AHCA looked at specific bills for TCM, Mr. Helms testified that:

> No, we did not review any claims level records, recipient or provider records. We, again were reviewing information to determine whether we felt that the allegations as provided by the attorney general's office were, in fact, credible based upon an indicia of reliability as we looked at the totality of the facts and circumstances. And that does not mean we're trying to prove or disprove a criminal case. We are conducting a preliminary investigation to essentially assess whether we feel like those are credible allegations.

44. Mr. Helms testified that no AHCA employee examined any claims pertaining to specific patients prior to April 14, 2016. As a result, Mr. Helms had no knowledge of any particular instance in which a procedure code was fraudulently entered for any specific patient.

45. Mr. Helms considers the source of an allegation to be a crucial part of assessing whether there is a credible allegation of fraud, and he stated multiple times during his testimony that he considers MFCU to be the best source for credible allegations of fraud. In fact, Mr. Helms testified that an allegation from MFCU was the highest order of allegation that AHCA could receive.

46. As for the nature of the allegations, Mr. Helms testified that "[w]hatever things they [MFCU] might have

reviewed were not known to us, but what we did have was the allegation of billing for services not rendered."

47. Mr. Helms testified that the source of the allegations and the nature of the allegations led AHCA to conclude that there were credible allegations of fraud:

> So when this allegation arrived to us, it already had that indicia [of reliability] because it was originating from the Medicaid Fraud Control Unit, and because the allegations were related to billing for services not rendered and billing for services for recipients who are not eligible. That's the focus of it. It was not about other factors.

48. Rather than being based on a review of facts, evidence, and information provided by MFCU or on information already in its possession, AHCA determined the allegations were credible because of their nature and because they were being made by MFCU.

49. On April 14, 2016, AHCA sent a letter (signed by Mr. Helms' supervisor Ms. Kelly Bennett) to Ms. Scharlepp notifying her that AHCA was suspending her Medicaid payments. AHCA mailed similar suspension letters (signed by Mr. Helms) to Ms. Hutto and PlayBig on April 15, 2016.

50. Each of the payment suspension letters stated the following:

> The Agency for Health Care Administration (AHCA), Medicaid Program Integrity, is temporarily suspending Medicaid payments to

> you pursuant to 42 C.F.R. § 455.23. This suspension of payments will remain in effect until the Agency or the prosecuting authorities determine there is insufficient evidence of fraud by the provider, or the legal proceedings related to the alleged fraud are completed. This suspension of Medicaid payments shall apply to all categories of payments.
>
> 42 C.F.R. § 455.23 provides that this notice must set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation. The general allegations are billing for services not rendered or not authorized.
>
> This action does not require any response on your part. However, if you believe that the basis for suspension set forth in this letter is incorrect, you may submit a written explanation, including any supporting documents or relevant materials for consideration to Tim Helms, AHCA Administrator either by way of email (Tim.Helms@ahca.myflorida.com) or via mail to the below address. Please be advised, however, that AHCA will not provide a response to your written explanation (if provided), further details about the investigation, or how long the payment restriction will be in place.

51. After the payment suspensions were imposed, Mr. Helms and Ms. Bennett met with Investigator Ormerod on April 18 or 19, 2016. During that meeting, Mr. Ormerod stated that PlayBig was billing the same recipient, regardless of apparent need, for various therapy services (i.e., physical, occupational, speech and behavioral) along with TCM. According to Mr. Helms, that

statement indicated PlayBig was "maximizing revenue opportunities."

52. Mr. Ormerod also stated during this meeting that PlayBig was billing Medicaid for services rendered to siblings or relatives of PlayBig clients, even though those siblings or relatives lacked the required diagnosis.

53. Mr. Ormerod further stated during this meeting that a targeted case manager employed by PlayBig was billing Medicaid for services when she should have been on duty at her job with the State of Florida.

54. This targeted case manager and state employee was Kim Hackler Jones, the sister of Ms. Hutto.

55. According to Mr. Helms, the meeting with Investigator Ormerod "confirmed, solidified our conclusion that we made the right decision in determining that we concurred with the credible allegation of fraud assertion."

56. However, there was no evidence or testimony regarding the basis for the aforementioned statements by Investigator Ormerod. For example, there was no testimony that his statements were based on an examination of documents seized during the search of PlayBig's location on April 14, 2016.[4/]

57. Petitioners retained legal counsel, who sent a letter to Ms. Bennett and Mr. Helms on April 21, 2016, asserting good

cause existed for AHCA to exercise its discretion under 42 C.F.R. § 455.23 and lift the payment suspension:

> As you may be aware, PlayBig is a unique and cutting edge Medicaid provider that takes a multi-speciality approach to the treatment of pediatric patients with autism and related conditions. PlayBig appropriately combines developmental therapies and behavioral health therapies in a holistic treatment approach. Such an integrated approach is otherwise unavailable in the Big Bend area.
>
> A large percentage of PlayBig's patients are Medicaid beneficiaries with a wide array of developmental and behavioral health conditions. The vast majority of these Medicaid beneficiaries are medically unserved individuals who, in many cases, are severely socio-economically disadvantaged. Many of these patients have been unable to find treatment in the Big Bend area for their children or found treatment that, in many cases, was fragmented and ineffective. For these patients and their families, the services provided by PlayBig have been a Godsend.

58. As for the consequences if the payment suspension were to remain in effect, Petitioners' counsel stated that:

> [I]t will not be financially feasible to continue treating Medicaid patients. Because of the large number of staff that PlayBig utilizes to treat Medicaid patients, PlayBig will, very shortly, perhaps as early as next week, be unable to continue to pay its therapists and staff. Those therapists and staff will be unable to remain at PlayBig as they will have to seek work elsewhere. Consequently, over 300 Medicaid patients, plus the numerous patients on PlayBig's waiting list, will be forced back

> into a community for which sufficient treatment resources are not available.

59. AHCA determined on May 3, 2016, that there was no good cause to rescind the payment suspension.

60. On April 26, 2016, Petitioners filed Petitions asking AHCA to refer these matters to DOAH for formal administrative hearings.

61. AHCA responded on April 28, 2016, by asking its Agency Clerk to dismiss the Petitions. In support thereof, AHCA argued that Petitioners were not entitled to formal administrative hearings because the payment suspensions were merely temporary in nature and not final agency action.

62. AHCA also argued that the payment suspension amounted to a contractual dispute that could not be adjudicated in an administrative forum. In doing so, AHCA cited Diaz v. State, 65 So. 3d 78 (Fla. 3d DCA 2011), in which the appellate court held that health care providers were required to pursue a circuit court action in order to challenge a unilateral decision by a state agency to terminate a Medicaid provider agreement.

63. Petitioners responded to AHCA's Motions to Dismiss by filing Responses citing content from a "Frequently Asked Questions" feature on AHCA's website. The content in question addressed "Payment Holds Due to a Credible Allegation of Fraud" and stated the following:

> Q. Is a provider placed on payment hold allowed a due process hearing, or other legal remedy?
>
> A. Yes. A provider may request hearing rights under Chapter 120, Florida Statutes.
>
> Additionally, 409.913(13), Florida Statutes states: If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment shall become due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold medical assistance reimbursement payments until the amount due is paid in full.

64. On May 9, 2016, the Agency Clerk issued Orders denying AHCA's Motions to Dismiss. In doing so, the Agency Clerk rejected AHCA's argument that Petitioners were not entitled to a formal administrative hearing:

> Section 120.569(1), Florida Statutes, applies in "all proceedings in which the substantial interests of a party are determined by an agency." [PlayBig] has alleged that its substantial interests have been affected by the Agency's action, as well as substantially complied with the other pleading requirements of rule 28-106.2015, Florida Administrative Code. Additionally, as [PlayBig] pointed out in its Response to Motion to Dismiss, A Community Home Health, Inc. d/b/a We Love to

> Care Home Health and Douglas Nalls, M.D., v. Agency for Health Care Administration, 1993 WL 943997 (Fla. Div. Admin. Hrgs.), specifically held that the Agency's action here is administrative in nature, and thus subject to chapter 120, Florida Statutes. In addition, [PlayBig] also pointed out that the Agency itself informs providers that a suspension of payments is subject to administrative review. See Exhibit B of Respondent's Response to Motion to Dismiss. Therefore, there is no basis upon which the undersigned could grant Petitioner's Motion at this time.

65. Petitioners' cases were referred to DOAH on May 12, 2016, and assigned DOAH Case Nos 16-2604MPI, 16-2605MPI, and 16-2606MPI.

66. AHCA was concerned that it would be forced to disclose information that would compromise MFCU's ongoing criminal investigation of Petitioners during the course of any administrative litigation.

67. Accordingly, on May 18, 2016, Ms. Bennett wrote letters notifying Petitioners that the payment suspensions were being lifted:

> In a letter dated April 15, 2016, the Agency for Health Care Administration, (Agency) Office of the Inspector General, Medicaid Program Integrity, advised you that the Agency had temporarily suspended Medicaid payments to you pursuant to 42 C.F.R. §455.23. The Agency is hereby discontinuing the payment suspension of the above noted Medicaid Provider number(s) and you have no further obligations regarding the previous letter.

68. Petitioners also received letters from Mr. Helms on May 18, 2016, notifying them that their Medicaid claims would be subject to prepayment review:

> Pursuant to Section 409.913(3), Florida Statutes, the Agency for Health Care Administration (Agency) has determined that a prepayment review be conducted on your Medicaid claims. This action is effective for those claims currently in the system for processing as well as claims submitted after this date. These claims will be suspended by the Agency for review prior to processing.
>
> You are required to provide copies of Medicaid-related records for review in order to support all claims submitted to the Medicaid program. Documentation for all claims is due within fifteen (15) days of your receipt of this letter. If documentation is not submitted timely, claims may be denied. In accordance with Section 409.913, F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. Pursuant to the aforementioned provisions, failure to provide all Medicaid-related records in compliance with this request will result in the application of sanctions, which include, but are not limited to, fines, suspension, and termination.

69. Under prepayment review, a Medicaid provider that bills AHCA directly (i.e., a fee-for-service provider) must furnish AHCA with documentation to substantiate the propriety of Medicaid claims, and the provider receives no compensation until

AHCA reviews the documentation and agrees that the claims were proper.

70. However and as mentioned previously, Petitioners are not fee-for-service providers. Petitioners are compensated by one or more managed care organizations that contract with AHCA for the provision of services to Medicaid beneficiaries. As a result, there is no evidence that imposition of the prepayment review caused any delay to Petitioners' receipt of payment for their Medicaid claims or detrimentally impacted Petitioners' business in any manner.

71. At this point, PlayBig had prevailed over AHCA by obtaining a formal administrative hearing and having the payment suspension lifted.

72. On May 19, 2016, the undersigned issued an Order consolidating DOAH Case Nos 16-2604MPI, 16-2605MPI, and 16-2606MPI ("the underlying cases").

73. On May 24, 2016, AHCA filed a Motion to Dismiss asserting the underlying cases were now moot given AHCA's decision to end the payment suspension. AHCA also repeated its earlier arguments by asserting there had been no final agency action and that the controversy between itself and Petitioners amounted to a contractual dispute.

74. Petitioners filed a Response in opposition to AHCA's Motion to Dismiss on May 31, 2016. However, the parties also

filed that day a "Stipulation for Dismissal of Petitions for Formal Administrative Hearing" noting the parties' agreement that the underlying cases were moot.

75. On June 6, 2016, the undersigned issued an Order closing the file of DOAH and relinquishing jurisdiction back to AHCA.

76. On July 11, 2016, Petitioners filed a "Petition and Application for Attorneys' Fees demanding an award of attorneys' fees and costs pursuant to section 57.111.

77. As of November 10, 2016, MFCU's investigation of Petitioners was continuing, and MFCU has taken no legal action against Petitioners.

CONCLUSIONS OF LAW

78. DOAH has personal and subject matter jurisdiction in this proceeding pursuant to sections 57.111(4), 120.569, and 120.57(1), Florida Statutes (2016). The Administrative Law Judge has final order authority in this matter. § 57.111(4)(d), Fla. Stat.

79. The Florida Legislature has found that small business parties "may be deterred from seeking review of, or defending against, unreasonable governmental action because of the expense of civil actions and administrative proceedings. Because of the greater resources of the state, the standard for an award of attorney's fees and costs against the state should be different

from the standard for an award against a private litigant." § 57.111(2), Fla. Stat.

80. Accordingly, the Florida Legislature enacted section 57.111, also known as the Florida Equal Access to Justice Act ("FEAJA"), to "diminish the deterrent effect of seeking review of, or defending against, governmental action by providing in certain situations an award of attorney's fees and costs against the state." § 57.111(2), Fla. Stat.

81. Section 57.111 directs that unless otherwise provided by law, a reasonable sum for "attorney's fees and costs" shall be awarded to a private litigant when all five of the following predicate findings are made:

> 1. An adversarial proceeding was "initiated by a state agency."
>
> 2. The private litigant against whom such proceeding was brought was a "small business party."
>
> 3. The small business party "prevail[ed]" in a proceeding initiated by a state agency.
>
> 5. The agency's actions were not substantially justified.
>
> 4. No special circumstances exist that would make an award of fees unjust.

82. In the instant case, the parties have stipulated that Petitioners are small business parties within the meaning of section 57.111. Therefore, the only issues to be resolved are the following: (a) did AHCA initiate an administrative

proceeding; (b) were Petitioners prevailing parties; (c) were AHCA's actions substantially justified; and (d) do any special circumstances exist that would make an award of attorney's fees and costs. Each of those issues will be separately addressed below.

Did AHCA Initiate an Administrative Proceeding by Suspending Petitioners' Medicaid Payments?

83. Section 57.111(3)(b) provides that the term "initiated by a state agency" means that the state agency: (a) "[f]iled the first pleading in any state or federal court in this state"; (b) "[f]iled a request for an administrative hearing pursuant to chapter 120"; or (c) "[w]as required by law or rule to advise a small business party of a clear point of entry after some recognizable event in the investigatory or other free-form proceeding of the agency."

84. The first two descriptions of "initiated by a state agency" are clearly inapplicable to the instant case. Therefore, Petitioners must demonstrate that AHCA was required to advise them of their right to request a formal administrative hearing. See Vause v. Dep't of Nat. Res., DOAH Case No. 89-2101F (Final Order May 24, 1989)(concluding that "[i]n proceedings under Section 57.111, the Petitioner bears the initial burden of proving that it is a small business party, that it prevailed, and that the underlying adjudicatory

proceeding pursuant to Chapter 120 was initiated by s state agency. Once this showing is made, the burden shifts to the Agency to demonstrate that its actions were substantially justified or that special circumstances exist which would make the award unjust.").

85. Pursuant to 42 C.F.R. § 455.23(a)(3), "[a] provider may request, and must be granted, administrative review where State law so requires." (emphasis added).

86. With regard to Florida law, section 120.569(1), Florida Statutes (2016), specifies that "[t]he provisions of this section apply in all proceedings in which the substantial interests of a party are determined by an agency, unless the parties are proceeding under s. 120.573 or s. 120.574." See also § 120.52(13)(a), Fla. Stat. (2016)(defining "party" as "[s]pecifically named persons whose substantial interests are being determined in the proceeding.").

87. Without a doubt, Petitioners were parties in the previous proceedings before AHCA and DOAH, and Petitioners' substantial interests were at stake because AHCA had suspended their Medicaid payments. Therefore, Petitioners were entitled to be advised of a clear point of entry into the administrative process. See generally Ft. Myers Real Estate Holdings, LLC v. Dep't of Bus. & Prof'l Reg., Div. of Pari-Mutuel Wagering, 53 So. 3d 1158, 1162 (Fla. 1st DCA 2011)(noting "[i]t is self-

evident that the permit applicant has standing to challenge the denial of its own application. The applicant is a 'party' to the permitting proceeding by operation of law because it is the specifically named person whose substantial interests are being determined by the agency's denial of the permit. Accordingly, the permit applicant need not establish its standing under the '*Agrico* test,' which requires the type of non-speculative injury-in-fact that the Division found lacking in Appellant's amended petition.")(internal citations omitted).

88. AHCA has argued that Petitioners were not entitled to a formal administrative hearing because AHCA had not taken "final agency action" against them.

89. However, whether AHCA has taken "final agency action" is irrelevant to this analysis because DOAH is not an appellate tribunal. See Hill v. Div. of Ret., 687 So. 2d 1376, 1377 (Fla. 1st DCA 1997)(noting that a party adversely affected by final agency action is entitled to judicial review). As discussed above, AHCA's suspension of Petitioners' Medicaid payments impacted their substantial interests. Accordingly, AHCA was required to provide Petitioners with a clear point of entry to the remedies available through the Administrative Procedure Act. See Capeletti Bros. v. State, 362 So. 2d 346, 348 (Fla. 1st DCA 1978)(stating that "an agency must grant affected parties a clear point of entry, within a specified time after some

recognizable event in investigatory or other free-form proceedings, to formal or informal proceedings under Section 120.57.").[5/]

90. In addition to arguing that it had taken no final agency action against Petitioners, AHCA argued Petitioners' only remedy was to file a contract enforcement action in circuit court in order to seek enforcement of their Medicaid provider agreements. In support of that position, AHCA cited Diaz.

91. While Diaz holds that a health care provider was required to pursue a circuit court action in order to challenge a state agency's decision to unilaterally terminate a Medicaid provider agreement, the opinion also contains a passage which conclusively undermines AHCA's assertion that Petitioners are not entitled to a formal administrative hearing to counter allegations of fraud:

> The instant Provider Agreement contains no dispute resolution clause, and the parties did not otherwise agree to settle their dispute in a specific forum. Nor is there a legal requirement that a dispute over the termination without cause of a Provider Agreement be heard in an alternative forum. The Diaz appellants argue that because the Legislature has authorized a series of administrative sanctions applicable to providers who commit specific fraudulent or abusive acts, see generally § 409.913, Fla. Stat. (2009) (detailing numerous sanctions applicable to certain behaviors, and providing for chapter 120 administrative hearings in the context of Medicaid overpayment disputes), a dispute over the

> termination of a Provider Agreement without cause must, in the name of fundamental fairness, be settled administratively. We disagree.
>
> By its own wording, section 409.913 exists "to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate." Id. To further this objective, the Legislature has simply required that the agencies respond administratively when a provider engages in fraudulent or abusive practices. Outside of fraud or abuse, there is no such requirement. Thus, it is not, as the Diaz appellants contend, fundamentally unfair to refer a dispute over the termination of a Provider Agreement without cause—where no issue of fraud or abuse is implicated—to the circuit court.

Diaz, 65 So. 3d at 81-82. (emphasis added).

92. In the April 14 and 15, 2016, letters notifying Petitioners that their Medicaid payments had been suspended, AHCA cited 42 C.F.R. § 455.23 rather than any contractual provision in the Medicaid provider agreements implicating its contractual authority. As a result, there can be no good faith dispute that AHCA was exercising is regulatory authority under section 409.913, Florida Statutes, when it suspended Petitioners' Medicaid payments.

93. In sum, Petitioners have demonstrated that AHCA was required to advise them of a clear point of entry in administrative proceedings.[6/]

Were Petitioners Prevailing Parties?

94. Section 57.111(3)(c) describes the circumstances in which a small business party will be deemed to be a "prevailing small business party." Subsection (3)(c)2. describes the only circumstance relevant to the instant case and states a small business party has prevailed when "[a] settlement has been obtained by the small business party which is favorable to the small business party on the majority of the issues which such party raised during the course of the proceeding . . . ."

95. The dispute between Petitioners and AHCA involved the payment suspension and AHCA's opposition to Petitioners having an opportunity to contest that suspension through a formal administrative hearing.

96. After AHCA's Clerk granted Petitioners' request and referred their dispute over the payment suspension to DOAH, AHCA promptly lifted the payment suspension. As testified by Mr. Helms, AHCA did so because it was concerned that a formal administrative hearing would compromise MFCU's ongoing criminal investigation.

97. Nevertheless, Petitioners have clearly carried their burden of demonstrating that they are prevailing parties. AHCA's lifting of the payment suspension amounted to an unconditional surrender.

98. AHCA argues that section 57.111(3)(c)2. cannot apply to the instant case because there was no oral or written settlement agreement between the parties.

99. While there may not have been a meeting of the minds between the parties, AHCA clearly capitulated, and Petitioners clearly prevailed. It would be absurd to interpret the term "settlement" in section 57.111(3)(c)2. as requiring that there be an agreement between the parties. See Williams v. State, 492 So. 2d 1051, 1054 (Fla. 1986)(stating that "[s]tatutes, as a rule, will not be interpreted so as to yield an absurd result."). If that were the case, agencies acting without substantial justification could avoid an award of fees by taking unilateral action to remedy a situation after realizing that a small business party was about to prevail.

100. AHCA has also argued that Petitioners were not prevailing parties because AHCA replaced one payment restriction (suspension) with another (prepayment review).

101. However, the facts demonstrate that this argument is not well-taken. When the payment suspension was in effect, Petitioners were receiving no Medicaid payments, and the April 21, 2016, letter from Petitioners' counsel indicates that Petitioners' business was suffering. In contrast, the prepayment review resulted in no delay whatsoever in Petitioners receiving Medicaid payments, and there was no evidence that the prepayment

review had any deleterious impact on Petitioners' operations or profitability.[7/]

Were AHCA's Actions "Substantially Justified?"

102. Section 57.111(4)(a) provides that a party seeking an award of fees and costs pursuant to the FEAJA is not entitled to an award if the agency can demonstrate that its actions were "substantially justified."

103. In order to be "substantially justified," the agency's action must have "had a reasonable basis in law and fact at the time it was initiated by a state agency." § 57.111(3)(e), Fla. Stat.

104. The agency has the burden of proving by a preponderance of the evidence that its actions were "substantially justified." See Dep't of HRS v. South Beach Pharmacy, 635 So. 2d 117, 121 (Fla. 1st DCA 1994)(noting that "once a prevailing small business part proves that it qualifies as such under section 57.111, the agency that initiated the main or underlying proceeding has the burden to show substantial justification or special circumstances."); § 120.57(1)(j), Fla. Stat. (2016)(providing that "[f]indings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute, and shall be based exclusively on the evidence of record and on matters officially recognized.").

105. With regard to the instant case, AHCA's substantial justification defense is primarily based on its assertion that AHCA satisfied its duty under the pertinent federal regulations.

106. Specifically, 42 C.F.R. § 455.23(a)(1) mandates that "[t]he State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity . . . ." (emphasis added).

107. As for what allegations are considered "credible," 42 C.F.R. § 455.2 provides that a credible allegation is one that "has been verified by the State." (emphasis added). Also, "[a]llegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis." Id.

108. MFCU failed to provide enough information to enable AHCA to verify that MFCU's allegations were credible. The testimony from Mr. Helms and Captain Bergert indicated that MFCU notified AHCA during the April 14, 2016, meeting of the allegations against Petitioners and the fact that MFCU had executed a search warrant that morning.

109. However, that was the extent of the information provided by MFCU. Despite conducting a search of PlayBig's

location earlier that day, Captain Bergert and Director Varnando did not bring any documents from that search with them to the meeting. In addition, Captain Bergert and Director Varnando did not identify any specific claims they considered to be fraudulent.[8/]

110. After receiving the CAF letter (which simply repeated the allegations against Petitioners), AHCA initiated its preliminary investigation and learned that Petitioners have reported multiple addresses, utilized multiple provider numbers, and used the wrong type of provider number in their Medicaid billings. However and as found above, there is nothing fraudulent about those activities, and there was no testimony that the foregoing activities contributed to any fraud allegedly committed by Petitioners.

111. In addition, AHCA attempted to use FFMIS to verify the allegations that: (a) Petitioners were billing TCM concurrently or on the same date as therapy services; and that (b) Petitioners were billing TCM for family members of Medicaid recipients who lacked the necessary diagnosis.

112. During his testimony, Mr. Helms did not explain how AHCA's preliminary investigation verified the allegations against Petitioners. In other words, Mr. Helms explained that AHCA conducted a preliminary investigation, but there was no

testimony about how the preliminary investigation's results verified the credibility of MFCU's allegations.

113. The testimony clearly and persuasively indicates that AHCA's assessment of the allegations against Petitioners was overwhelmingly, if not exclusively, based on: (a) the source of the allegations, i.e., MFCU; and (b) the nature of the allegations.

114. The pertinent federal regulations do not excuse AHCA from evaluating the credibility of allegations if their source is the entity responsible for prosecuting Medicaid fraud. Nor do those regulations excuse AHCA from performing the necessary assessment if the allegations in question are of a certain nature. If circumstances such as the foregoing excused state Medicaid agencies from verifying whether allegations are credible, then the federal regulations would contain language to that effect. See generally Gretna Racing, LLC v. Dep't of Bus. & Prof'l Reg., Div. of Pari-Mutuel Wagering, 178 So. 3d 15, 26 (Fla. 1st DCA 2015)(noting that "if the Legislature truly intended to immediately expand the authority of counties to hold referenda on slot machines, without future 'statutory or constitutional authorization' for such referenda, it assuredly would have amended a critical portion of the slot machine statute . . . .").

115. AHCA argued that the search warrant (AHCA's Exhibit 4) obtained by MFCU demonstrates that the allegations were credible. Petitioners objected to the undersigned accepting the search warrant into evidence, and the undersigned has determined that the search warrant should not be accepted into evidence because it was not in AHCA's possession when the decision was made to suspend Petitioners' Medicaid payments. See Dep't of Health, Bd. of Physical Therapy Practice v. Cralle, 852 So. 2d 930, 932 (Fla. 1st DCA 2003)(the substantial justification determination must be based on the information available to the agency when the agency took the action at issue).

116. Nevertheless, even if the undersigned were to accept the search warrant into evidence, it would not further AHCA's substantial justification defense. The search warrant contains no information about what information led the circuit court judge to sign the warrant. In fact, the search warrant does not even enumerate MFCU's allegations against Petitioners.

117. Moreover, any weight or credibility that could be assigned to this search warrant is lessened by the fact that the authorities do not have to clear a high evidentiary bar in order to obtain a search warrant. See Cano v. State, 884 So. 2d 131, 135-36 (Fla. 2d DCA 2004)(noting "[i]t is well established that a search warrant can be issued based upon affidavits and hearsay

evidence. There is no requirement that probable cause to issue a search warrant be based only on evidence that would be competent at trial. The type of thorough consideration given at trial to relevance or to the prejudicial effect of evidence versus its probative value is not feasible or appropriate when a magistrate issues a search warrant.").

118. In sum, AHCA failed to satisfy its duty to verify that MFCU's allegations of fraud were credible. Therefore, AHCA's suspension of Petitioners' Medicaid payments was not substantially justified within the meaning of section 57.111.[9/]

Are There Any "Special Circumstances" That Would Make an Award of Fees and Costs Unjust?

119. In addition to demonstrating that its actions were "substantially justified," a state agency can avoid paying fees and costs under section 57.111 if it can demonstrate that there are special circumstances that would make an award of fees and costs unjust. See § 57.111(4)(a), Fla. Stat. (mandating that "an award of attorney's fees and costs shall be made to a prevailing small business party in any adjudicatory proceeding or administrative proceeding pursuant to chapter 120 initiated by a state agency, unless the actions of the agency were substantially justified or special circumstances exist which would make an award unjust.").

120. Section 57.111 does not define the term "special circumstances." However, "the use of the word 'special' connotes something unusual or unique." Brown v. Bd. of Psychological Exam'r, Case No. 92-6307F, 1993 Fla. Div. Admin. Hear. LEXIS 5362 (Fla. DOAH August 24, 1993)(concluding that "none of these circumstances rises to a level of being so special or unique as to excuse respondent's actions.").

121. As noted above, the FEAJA is modeled after the Federal Equal Access to Justice Act, and federal case law provides some guidance regarding the proper interpretation of "special circumstances" in the state statute. For instance, federal case law states that "[t]he EAJA's 'special circumstances' exception is a 'safety valve' that gives 'the court discretion to deny awards where equitable considerations dictate an award should not be made." Vincent v. Comm'r of Soc. Sec., 651 F.3d 299, 303 (2d Cir. 2011). See also Horton v. Barnhart, 2004 U.S. Dist. LEXIS 4063, *7 (S.D. N.Y. 2004)(noting that "[t]he terms 'special circumstances' and 'unjust' have not been defined and thus the court should be guided by general principles of equity."). However, what amounts to a "safety valve" is indistinct because federal case law also states that "if the 'special circumstances' exception is to function as an equitable 'safety valve,' its contours can emerge only on a case-by-case basis." Vincent, 651 F.3d at 303.

122. AHCA argues that the arrest of Kimberly Hackler Jones, Kelly Hutto's sister, amounts to a special circumstance. In support of this argument, AHCA requested the undersigned to officially recognize the arrest warrant affidavit (AHCA's Exhibit 15). AHCA's request was based on section 90.203, Florida Statutes (2016), which requires a court to take judicial notice of any matter within section 90.202 if that party has: (a) given the opposing party timely written notice; and (b) given the court sufficient information to enable it to take judicial notice of the matter.

123. AHCA provided Petitioners with written notice via a Motion filed on November 7, 2016, three days prior to the final hearing. In addition, the arrest warrant appears to be a court record within the meaning of section 90.202(6), Florida Statutes (2016).

124. Nevertheless, the arrest warrant affidavit will not be officially recognized because it is filled with numerous hearsay statements regarding Ms. Hackler Jones' allegedly fraudulent Medicaid billings that are being offered for the truth of the matter asserted. See Stoll v. State, 762 So. 2d 870, 876 (Fla. 2000)(stating that "[a]lthough a trial court may take judicial notice of court records, it does not follow that this provision permits the wholesale admission of all hearsay statements contained within those court records. We have never held that

such otherwise inadmissible documents are automatically admissible just because they were included in a judicially noticed court file.")(internal citations omitted).

125. Even if the undersigned had accepted the arrest warrant affidavit into evidence, AHCA would not be able to carry its burden of demonstrating the presence of special circumstances. The statements within the arrest warrant pertain to Ms. Hackler Jones' conduct. Because Ms. Hackler Jones is just one PlayBig employee, her arrest, by itself, is insufficiently compelling to excuse AHCA from acting without substantial justification.[10/] AHCA would have had a much stronger special circumstances argument if there had been arrests of Ms. Hutto, Ms. Scharlepp, and/or multiple PlayBig employees. In addition, AHCA's special circumstances argument would have been especially compelling if MFCU's seven-month investigation had resulted in Ms. Hutto or Ms. Scharlepp being indicted for Medicaid fraud.

126. In sum, AHCA has failed to demonstrate that special circumstances are present in the instant case.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, Petitioners have demonstrated that they are entitled to an award of attorney's fees and costs pursuant to section 57.111, that AHCA was not substantially justified in taking the action to suspend Petitioners' Medicaid payments, and that there exist

no special circumstances that would make an award of attorney's fees and costs unjust. Thus, Petitioners' "Petition and Application for Attorneys' Fees" is GRANTED. Jurisdiction is retained so that the undersigned can conduct a second hearing (if necessary) to address the reasonableness of the attorney's fees and costs sought by Petitioners. Accordingly, it is ORDERED that the parties shall confer to determine if agreement can be reached on the amount of attorney's fees and costs. The parties shall notify the undersigned in writing on or before February 10, 2017, if such agreement has been reached. If the parties are unable to reach an agreement, then they shall provide several mutually-agreeable dates on which a hearing will be conducted on the reasonableness of the fees and costs.

DONE AND ORDERED this 27th day of January, 2017, in Tallahassee, Leon County, Florida.

Garnett Chisenhall

G. W. CHISENHALL
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 27th day of January, 2017.

ENDNOTES

[1/] Unless indicated otherwise, all statutory references will be to the 2015 version of the Florida Statutes.

[2/] Petitioners' Exhibit 10 is a composite of all exhibits to a deposition of AHCA Administrator Tim Helms. Petitioners' Deposition Exhibits 7, 8, 10, and 11 were excluded from evidence and/or withdrawn.

[3/] Mr. Helms' testimony indicates that AHCA's ability to verify MFCU's allegations through FFMIS was limited at best. For instance, when asked what was wrong with providing TCM and therapy on the same day, Mr. Helms responded as follows:

> Not necessarily anything. But again, the assertion, as it was made based upon the allegations from [MFCU], one of the things that they stated was that these services were being rendered while there were other activities taking place. And again, I was unable to, without reviewing documents or records, necessarily know was it the exact time.
>
> But the indicia of reliability that we used to review that was, when we looked at the basis – the FFMIS claims information, we could see same dates of service that would – that would indicate the indicia of reliability that [MFCU] was providing us with information that seemed to be accurate. It was credible.

With regard to the allegation that PlayBig was billing for TCM for the family members of Medicaid recipients when the family members lacked the necessary mental health diagnosis, Mr. Helms testified that AHCA reviewed FFMIS to see if TCM services were being received by people with similar names. However, Mr. Helms did not explain the outcome of that review or how it led AHCA to conclude that MFCU's allegations were credible.

[4/] Petitioners objected to any testimony regarding the meeting between AHCA and MFCU on April 18 or 19, 2016. The undersigned allowed the testimony because it could have been relevant to AHCA's "special circumstances" defense. After reviewing all of

the evidence, the undersigned is of the opinion that the meeting does nothing to demonstrate that special circumstances are present in the instant case. As for AHCA's substantial justification defense, the meeting cannot be considered because it occurred after AHCA suspended Petitioners' Medicaid payments. See McCloskey v. Dep't of Fin. Servs., 172 So. 3d 973, 976 (Fla. 5th DCA 2015)(noting that "[s]ubstantial justification must exist at the time the agency initiates the action as '[s]ubsequent discoveries do not vitiate the reasonableness of the actions of the [agency] at the time they made their probable cause determinations.'"). However, even if the meeting could be considered in the substantial justification analysis, the undersigned would conclude that Mr. Helms' testimony about the meeting did not bolster AHCA's defense. As noted above, there is no indication that Investigator Ormerod's statements were based on evidence seized during the search of PlayBig's location. Instead, it appears that the meeting between AHCA and MFCU on April 18 or 19, 2016, mirrored what occurred on April 15, 2016, when MFCU made allegations about Petitioners without furnishing any evidence to support those allegations.

[5/] The April 14 and 15, 2016, letters' offer for Petitioners to submit a written explanation and/or supporting documents for Mr. Helms' consideration was no substitute for a notice of hearing rights. See Gen. Dev. Utils. v. Fla. Dep't of Envtl. Reg., 417 So. 2d 1068, 1070 (Fla. 1st DCA 1982)(noting that "[t]he fact that the petitioners can submit additional or contrary information on the disputed issues of material fact in hopes that DER will reconsider its position is not a substitute for a 120.57 hearing upon request.").

[6/] The undersigned appreciates that a formal administrative hearing under circumstances similar to those of the instant case could compromise an ongoing criminal investigation. See generally A Community Home Health, Inc., d/b/a We Love to Care Home Health and Douglas Nalls, M.D. v. Ag. for Health Care Admin., DOAH Case No. 93-4194 (Recommended Order Nov. 3, 1993)(noting that "[t]he confidentiality afforded the MFCU investigation by Section 409.913(7), Florida Statutes, makes it difficult for Respondent to prove its case. That difficulty does not, however, relieve Respondent from its burden of proof in this proceeding."); § 409.913(12), Fla. Stat. (2016) (providing that "[t]he complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1)"). However, even

when an agency issues an emergency order summarily suspending a license because the licensee's continued activity represents an immediate danger to the public's health, safety, or welfare, the licensee is entitled to a prompt administrative proceeding. See Fla. Admin. Code R. 28-106.501(3)(mandating that "[i]n the case of the emergency suspension, limitation, or restriction of a license, unless otherwise provided by law, within 20 days after emergency action taken pursuant to subsection (1) of this rule, the agency shall initiate administrative proceedings in compliance with Sections 120.569, 120.57 and 120.60, F.S. and Rule 28-106.2015, F.A.C.").

Under 42 C.F.R. § 455.23(c), a suspension will remain in place until: (a) it is determined that there is insufficient evidence of fraud; or (b) legal proceedings related to the alleged fraud are completed. However, 42 C.F.R. § 455.23(a)(3) mandates that a Medicaid provider must be granted administrative review "where State law so requires." Denying Medicaid providers a clear point of entry until completion of a criminal investigation could very well amount to an indefinite suspension of Medicaid payments in many cases, and federal courts have held that "the government may not deprive a provider of such funds indefinitely without a hearing." Maynard v. Bonta, 2003 U.S. Dist. LEXIS 16201, *57 (D.C. Cal. 2003)(stating that "[w]hile holding generally that a provider has no property interest in Medicaid funds that are withheld pending an investigation of alleged fraud or illegality, federal courts have stated that the government may not deprive a provider of such funds indefinitely without a hearing."). For example, MFCU's investigation in the instant case began prior to its execution of the search warrant on April 14, 2016, but that investigation was still ongoing when the final hearing commenced seven months later on November 10, 2016. If a health care provider derives a substantial amount of its revenue from Medicaid payments, a seven-month suspension of those payments would likely put the provider out of business.

[7/] Petitioners objected to the undersigned accepting the prepayment review letters (AHCA Exhibit 14) into evidence. However, the undersigned concludes that they are relevant to the prevailing party question and should be accepted into evidence. As discussed above, Petitioners clearly prevailed when AHCA substituted the payment suspension with a prepayment review that had no deleterious impact on Petitioners' business.

[8/] MFCU's presentation of its allegations to AHCA is analogous to a prosecuting agency's presentation of allegations to a probable cause panel of board members. In the latter situation,

the probable cause panel is required to evaluate the allegations and not act as a "rubber stamp." See Kibler v. Dep't of Prof'l Reg., 418 So. 2d 1081. 1084 (Fla. 4th DCA 1982)(noting "[t]here was no evidence submitted or further discussion of the charge. In our view, this dialogue is better described as a 'rubber stamp' than a determination and is clearly in violation of section 455.255(3)."). The same principle should apply when MFCU asks AHCA to suspend a provider's Medicaid payments during the pendency of a criminal investigation. MFCU should present some evidence to support its allegations.

Captain Bergert testified during the final hearing that giving AHCA details of MFCU's investigation would compromise the investigation. However, he did not explain the rationale for his statement, and the undersigned is unable to independently surmise any rationale given that section 409.913, Florida Statutes (2016), charges AHCA with protecting the integrity of Florida's Medicaid program.

[9/] Petitioners also asserted in their "Petition and Application for Attorneys' Fees" that AHCA lacked substantial justification when it denied their request for a good cause exception to the suspension and opposed their request for a formal administrative hearing. Petitioners' assertion that AHCA lacked substantial justification for denying their request for a formal administrative hearing is more pertinent to the question of whether AHCA initiated an administrative proceeding, and that question was addressed in the appropriate section above. As for whether AHCA had substantial justification to deny AHCA's request for a good cause exception, that question has been rendered moot given the conclusion that AHCA lacked substantial justification when it suspended Petitioners' Medicaid payments.

[10/] The arrest warrant affidavit alleged there was probable cause to believe that Ms. Hackler Jones committed Medicaid fraud by knowingly violating section 409.920, Florida Statutes (2014-2015). In addition, the arrest warrant affidavit alleged there was probable cause to believe that Ms. Hackler Jones violated section 838.022(1)(a), Florida Statutes (2014-2015), by knowingly asserting on her time sheets that she was working for the Department of Highway Safety and Motor Vehicles when she was actually working for PlayBig. Obviously, the former charge is the only one directly relevant to the instant case.

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