STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

Case No. 20-2884MPI

vs.

ABELLA YOSE CARE SERVICES, INC.,

Respondent.
_____/

RECOMMENDED ORDER

On November 4, 2020, a final hearing was held via Zoom video teleconference, before Robert S. Cohen, an Administrative Law Judge assigned by the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: Bradley Stephen Butler, Esquire
Susan Sapoznikoff, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: Anthony Vitale, Esquire
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Miami Beach, Florida 33139

STATEMENT OF THE ISSUES

The issues presented are: (1) whether Petitioner is entitled to repayment of Medicaid overpayments to Respondent; and, if so, (2) the amount of the overpayment to be repaid; (3) whether Petitioner may impose a sanction against Respondent; and (4) whether Respondent must pay the investigative, legal, and expert witness costs that Petitioner incurred as a result of the audit and Respondent's petition.

PRELIMINARY STATEMENT

The State of Florida, Agency for Health Care Administration ("Petitioner," "Agency," or "AHCA"), performed an audit of the business records and Medicaid-related records (collectively "records") of Abella Yose Care Services, Inc. ("Respondent," "Billing Provider," or "Abella Yose"), for the period of November 1, 2017, through December 31, 2018 ("Audit Period").

The Agency reviewed Respondent's records during this audit to determine whether the rendering providers Respondent hired, employed, and supervised to provide Behavior Analysis ("BA") services to Medicaid recipients possessed the qualifications required by the Medicaid statutes and rules to be eligible to be paid by Medicaid for those claims.

The Agency issued a Final Audit Report ("FAR"), dated February 21, 2020. The FAR concluded that Petitioner overpaid Respondent $263,791.60 for services that, in whole or in part, were not covered by the Medicaid program. The FAR determined that, based upon a review of Respondent's records, five of the 27 rendering providers Respondent employed did not possess the qualifications necessary to be paid by Medicaid. The FAR additionally sought to impose sanctions of $2,500.00 pursuant to Florida Administrative Code Rule 59G-9.070(7)(c) and $52,758.32 pursuant to

rule 59G-9.070(7)(e) and costs in the amount of $528.00, incurred as a result of the audit. In sum, the Agency asserted that Respondent owed a total of $319,577.92.

Respondent timely requested an administrative hearing pursuant to sections 120.569 and 120.57(1), Florida Statutes, challenging the amounts assessed and the findings in the FAR. The petition also alleged an un-promulgated rule was employed by the Agency in reaching its determination, but Petitioner never filed an appropriate rule challenge nor specifically identified or attempted to further its case through testimony and evidence as to the un-promulgated rule. After an initial abeyance, the matter was referred to DOAH to conduct a final hearing, and the matter was assigned DOAH Case No. 20-2884MPI. On August 18, 2020, this matter was scheduled for hearing to occur on November 4 and 5, 2020. On November 4, 2020, the hearing commenced. As a preliminary matter, the undersigned addressed the prior denial of Respondent's "Motion to Exclude Final Hearing Testimony of Witnesses for Failure to Properly Testify at Deposition and for Sanctions" ("Motion to Exclude") and the "Agency's Motion to Deem Admitted or, in the Alternative, Compel Responses to Requests for Admissions" ("Motion to Deem Admitted"). After hearing from the parties, the undersigned upheld its denial of the Motion to Exclude and denied the Agency's Motion to Deem Admitted. Thereafter, the hearing commenced. The Agency offered Exhibits 1 through 12, which were admitted into evidence without objection. The Agency objected to Respondent's exhibits, and the Tribunal postponed ruling on the admissibility of Respondent's exhibits until Respondent provided support for those exhibits during testimony.

The Agency presented live testimony from Ms. Robi Olmstead, AHCA administrator, and Ms. Sharon Dewey, AHCA nurse consultant. Respondent

offered no witnesses, and Respondent's exhibits were not admitted into evidence.

The Transcript of the final hearing was filed on December 1, 2020. The parties had previously agreed to file proposed recommended orders by December 11, 2020. The Agency and Respondent timely filed Proposed Recommended Orders.

All references to the Florida Statutes are to the 2017 version, which was in effect at the time the disputed services were rendered. All references to the Florida Administrative Code rules are to the 2010 version.

FINDINGS OF FACT

I. The Parties

1. The Agency is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act, the "Medicaid Program." Petitioner is responsible for administering the Florida Medicaid Program in accordance with state and federal law. § 409.902(1), Fla. Stat.

2. The Agency is statutorily charged with operating 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." § 409.913, Fla. Stat.

3. During the Audit Period, Respondent was a Medicaid provider enrolled to provide BA services, had a valid Non-Institutional Medicaid Provider Agreement with AHCA, and was issued Medicaid Provider No. 021079700.

4. Respondent voluntarily contracted to be a Medicaid provider and was subject to the duly-enacted federal and state statutes, regulations, rules, policy guidelines, and Medicaid handbooks incorporated by reference into

rule, which were in effect during the Audit Period, and agreed to retain all Medicaid and Medicaid-related records to satisfy all necessary inquiries by the Agency.

5. The Agency's representative, Ms. Robi Olmstead, is the AHCA administrator for the Practitioner Unit of the Agency's Bureau of Medicaid Program Integrity ("MPI"). She has held that position since 2004 and oversees audits of Medicaid providers in that role. Ms. Olmstead has significant experience with Medicaid, being involved directly and indirectly with the Medicaid program in the state of Florida for over 35 years.

6. Ms. Olmstead has worked in the field of developmental disabilities since 1975 and is involved in Medicaid's Developmental Disabilities Individual Budgeting Waiver program (also referred to as the "DD Waiver" or "iBudget Waiver" program), a program which provides services to Medicaid recipients with developmental disabilities and predates the behavior analysis program.

II. Definitions

7. There are several terms that are defined by Florida Statutes and rules of the Florida Administrative Code within the Medicaid program that are used frequently in this case. To the extent that a term is used in this filing, it means its defined term as provided in this section.

8. "Business Records" means "[d]ocuments related to the administrative or commercial activities of a provider."

9. "Medicaid-related records" is defined as "[r]ecords that relate to the provider's business or profession and to a recipient[,]" including records that "determine a provider's entitlement to payments under the Florida Medicaid program."

10. "Recipient" is defined by the Florida Medicaid Definitions Policy (Aug. 2017), promulgated as Florida Administrative Code Rule 59G-1.010, as an "[i]ndividual determined to be eligible for Florida Medicaid covered

services by the Department of Children and Families or the Social Security Administration, and who is enrolled in the Florida Medicaid program."

11. "Recipient" is further clarified by the Florida Medicaid BA Services Coverage Policy ("BA Coverage Policy") as "an individual enrolled in Florida Medicaid (including managed care plan enrollees)."

12. "Services" is defined as "[a]ny diagnostic or treatment procedure(s) or other medical or allied care claimed to have been furnished to a recipient and listed in an itemized claim for payment; or, in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim."

13. Section 409.913(1)(e), Florida Statutes, defines "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."

14. Section 409.913(1)(a) defines "abuse," in pertinent part, as "[p]rovider practices that are inconsistent with generally accepted business … practices and that result in an unnecessary cost to the Medicaid program … ."

15. Section 409.901(6) defines "claim" as "any communication, whether written or electronic (electronic impulse or magnetic), which is used by any person to apply for payment from the Medicaid program or its fiscal agent for each item or service purported by any person to have been provided by a person to any Medicaid recipient."

16. An "audit" is defined as "an analysis of documentation supporting a provider's Florida Medicaid claims during a period of time, to determine whether payments were accurate." Fla. Medicaid Definitions Policy, § 2.9, August 2017.

III. General Audit and Record Keeping Requirements

17. Section 409.913(2) places an affirmative duty on the Agency to review, investigate, analyze, and audit the Medicaid program to determine possible fraud, abuse, overpayment, or recipient neglect.

18. Medicaid claims are paid under what is known as a "pay and chase" system. Claims are quickly paid under the presumption the provider is billing in accordance with Florida Medicaid statutes and rules. When paid claims are later audited and the Agency determines that a claim did not meet the requirements for payment by Medicaid, those payments are overpayments, as defined by section 409.913(1)(e), and the Agency issues an audit report and demands repayment of those improperly paid claims.

19. As part of the Agency's duties in overseeing the integrity of the Medicaid program, it investigates and audits Medicaid providers for services rendered to Medicaid recipients.

20. All Florida Medicaid providers are required to maintain, for at least five years, contemporaneous documentation of entitlement to payment, including employment eligibility, and compliance with all Medicaid rules, regulations, handbooks, and policies. *See* § 409.913(7), (21), (22), Fla. Stat.

21. Section 409.913(9) requires a Florida Medicaid provider to keep "medical, professional, financial, business and Medicaid-related records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods."

22. The "Record Keeping Requirement" section of the 2012 Florida Medicaid Provider General Handbook (applicable to the allegations giving rise to this proceeding) requires, in pertinent part, that all providers maintain business records, Medicaid-related records, and medical records.

23. The "Incomplete Records" section of the 2012 Florida Medicaid Provider General Handbook states: "Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped."

24. According to section (5)(b) of the Non-Institutional Medicaid Provider Agreement, Respondent was required "to maintain in a systematic and orderly manner, all medical and Medicaid-related records the agency requires and determines are relevant to the services or goods being provided."

IV. Behavior Analysis Service Specific Requirements

25. BA services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behavior. The individuals, who require these services, have mental health disorders, developmental or intellectual disabilities.

26. Prior to the implementation of the BA program, Medicaid recipients with developmental disabilities who required Medicaid services could obtain services primarily through the DD Waiver or iBudget Waiver program; and the BA program was opened to service the needs of "other children who were not in developmental disabilities to receive like services."

27. The Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, September 2015 (the "Handbook"), states that providers who provide services to individuals with developmental disabilities must complete a Level II background screening in order to provide services to a Medicaid recipient with developmental disabilities. *See generally*, the Handbook, as incorporated by reference in Fla. Admin. Code R. 59G-13.070. The Handbook has subsequently been updated on three occasions, and the subsequent iterations have been incorporated by reference in the same rule.

28. Following the implementation of the BA program, a statewide assessment revealed rampant fraud and abuse within the BA program, including more than twice as many providers as recipients, providers billing not credible hours (such as more than 24 hours per day), and claims of provider qualifications that were facially dubious, resulting in BA services being claimed to and paid by Medicaid based on services from unqualified providers.

29. The Agency determined that services rendered by unqualified individuals would not only "not be a benefit to the recipient, but may in fact harm the recipient; resulting in regression or other harm."

30. In May 2018, the Agency imposed a temporary moratorium against new BA enrollments in Southeast Florida. Justin Senior, then Secretary of the Agency, issued a press release stating the Agency's "number one priority remains the children who rely on this service and making sure that they have high quality providers."

31. Based on information obtained in the statewide BA review, the Agency audited all BA group providers to determine whether they had sufficient documentation that their employees possessed the required qualifications and were eligible to provide services during the Audit Period.

32. The BA Coverage Policy identifies multiple, objective credentials that a rendering provider can provide that are a clear indication that a rendering provider is qualified to provide services in accordance with the policy, including being a:

> Board Certified Behavior Analyst (BCBA) credentialed by the Behavior Analyst Certification Board,
>
> Florida Certified Behavior Analyst (FL-CBA) credentialed by the Behavior Analyst Certification Board,
>
> Practitioner fully licensed in accordance with Chapters 490 or 491, F.S., with training and expertise in the field of behavior analysis,
>
> Board Certified Assistant Behavior Analyst (BCABA) credentialed by the Behavior Analyst Certification Board,
>
> Registered Behavior Technician (RBT), credentialed by the Behavior Analyst Certification Board.

33. With regard to "Behavior Assistants," Section 3.2 of the BA Coverage Policy sets forth an alternative method to qualify these individuals if they have previously provided services to Medicaid recipients who have certain mental health conditions. Behavior assistants must work under a lead analyst and meet one of the following:

> Have a bachelor's degree from an accredited university or college in a related human services field; [be] employed by or under contract with a group, billing provider, or agency that provides Behavior Analysis; and, agree to become a Registered Behavior Technician credentialed by the Behavior Analyst Certification Board by January 1, 2019.
>
> OR
>
> [Be] 18 years old or older with a high school diploma or equivalent; have at least two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities; and, complete 20 hours of documented in-service trainings in the treatment of mental health, developmental or intellectual disabilities, recipient rights, crisis management strategies and confidentiality.

34. To provide services to an individual enrolled in Florida Medicaid with mental health disorders, developmental, or intellectual disabilities, a provider must successfully pass a background screening, which is cataloged and maintained by the Agency's Background Screening Unit.

V. The Audit of Abella Yose

35. The Agency requested that Respondent, Abella Yose, provide all documentation it retained regarding Respondent's eligibility for payment from Medicaid for claims Respondent submitted for BA services.

36. The Agency requested records of provider eligibility from Respondent for all rendering providers, who provided the services claimed by Respondent and paid by Medicaid, which occurred during the "Audit Period."

37. The Agency did not place any limitation on what documentation Respondent could submit to provide support for its claims and provided a non-exhaustive list of examples of the types of documents which were generally submitted to the Agency.

38. During the Audit Period, Respondent submitted claims for services rendered by 27 rendering providers for which Medicaid paid Respondent a total of $830,416.49. Of the 27 providers the Agency reviewed, only five of the rendering providers that Respondent claimed were qualified as behavior assistants are at issue in this proceeding.

39. Based upon the audit, the Agency initially determined Respondent had been overpaid in the amount of $263,791.60 based on insufficient or no documentation being provided that five of its rendering providers met the qualifications.

40. The Agency issued a Preliminary Audit Report ("PAR"), dated October 31, 2019, notifying Abella Yose of the rendering providers deemed not qualified and the amount of overpayment associated with each. Abella Yose was given the opportunity to pay the PAR amount or submit additional records.

41. In response to the PAR, Abella Yose submitted additional records. Based on those additional records, the Agency issued the FAR, alleging Abella Yose was overpaid $263,791.60 for BA services it billed for five behavior assistant rendering providers, who did not have documentation demonstrating they met the criteria specified in the BA Coverage Policy.

42. In addition, the FAR informed Respondent that the Agency was seeking to impose a sanction of $52,758.32 pursuant to rule 59G-9.070(7)(e); a sanction of $2,500.00 pursuant to rule 59G-9.070(7)(c); and costs of $528.00 pursuant to section 409.913(23)(a). In sum, Petitioner asserted in the FAR that Respondent owed a total of $319,577.92.

43. The claims which make up the overpayment were filed by and paid to Respondent prior to the institution of this action.

44. Based on cited provisions in the 2012 Florida Medicaid Provider General Handbook and the BA Coverage Policy, the FAR indicates that: "Payments for Florida Medicaid Behavior Analysis Services rendered by an individual determined not to meet the qualifications or for whom documentation was insufficient to determine eligibility are considered an overpayment."

45. The FAR stated that "[p]rovider practices that are inconsistent with generally accepted business ... practices and that result in an unnecessary cost to the Medicaid program ... " are defined as "abuse" in section 409.913(1)(a)1.

46. None of the rendering providers at issue in this audit were lead analysts, board-certified assistant behavior analysts, or registered behavior technicians ("RBT"); the only providers at issue in this proceeding are the ones the Billing Provider claimed were qualified as behavior assistants.

47. Respondent did not provide any documentation to the Agency indicating that any of the rendering providers at issue had both a bachelor's degree (or more) "in a related human services field" and had obtained their RBT certification by January 1, 2019.

48. Each rendering provider at issue was at least 18 years old and had obtained at least a high school diploma or its equivalent, and each had "20 hours in-service trainings in the treatment of mental health, developmental or intellectual disabilities, recipient rights, crisis management strategies and confidentiality."

49. Accordingly, the FAR was based on the failure of Respondent to provide contemporaneous documentation that any of the rendering providers, who Respondent claimed were qualified by experience, had "at least 2 years' experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities."

50. During the hearing, the two years of experience requirement was referred to as the "Requisite Work Experience" requirement. Further, in

order to shorten an onerous term, "recipients with mental health disorders, developmental or intellectual disabilities" were referred to as the "target population."

51. In sum, for each of the individual rendering providers Respondent claimed was qualified to provide BA services to Medicaid recipients, Respondent was required to maintain and retain documentation that each rendering provider had met the minimum provider qualifications of possessing at least two years' experience providing direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities and to submit that contemporaneous documentation to the Agency upon request to audit those records.

52. Sharon Dewey is a registered nurse consultant with the Agency's MPI unit. In that capacity, she assists with MPI audits. She compiles and analyzes data; applies appropriate rules, regulations, policies, and procedures to oversee the activities of Florida Medicaid providers to detect fraudulent or abusive behavior and minimize the neglect of recipients; recovers overpayments; imposes sanctions; and makes referrals as appropriate to other agencies.

53. Ms. Dewey was responsible for reviewing the records provided by Abella Yose to determine whether the documentation submitted by Respondent supported Respondent's claims that each of the rendering providers at issue possessed the qualifications necessary to be eligible to provide BA services to Medicaid recipients.

VI. The Specific Rendering Providers

A. Anaidys Balada

54. The application for Anaidys Balada provided to the Agency by Respondent listed work experience as a home health aide ("HHA") with A & A Home Care and as a driver with Transport America. No dates of employment were listed on the application for either job. There was no

indication within the documentation provided that direct services were provided to the target population or that any of the individuals that Ms. Balada provided services to were Medicaid recipients.

55. The résumé for Ms. Balada, provided to the Agency by Respondent, listed work experience as an HHA with A & A Home Care. Dates of employment were listed as "3/2003 to 7/2013." While work duties were listed, there was no indication of providing direct services to the target population.

56. A & A Home Care provided documentation upon request from the Agency that indicated the information provided by Respondent was inaccurate. A & A Home Care provided adjusted dates of employment and stated that Ms. Balada did not provide direct services to the target population.

57. The job description provided by Ms. Balada's résumé for her position with A & A Home Care is identical to the job description for Maxim listed on Elizabeth Lozano's résumé (*see* ¶¶ 67-76).

58. The documents sent to the Agency by Respondent demonstrated that both Ms. Balada and Respondent presented her as an RBT even though Respondent provided no documentation Ms. Balada possessed that certification.

59. Respondent's documentation demonstrated Ms. Balada was first screened for work with Medicaid recipients in August 2017 and, therefore, could not lawfully provide direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities prior to this date.

60. Respondent sent additional documents to the Agency after receiving the PAR, but those submissions did not contain contemporaneous documentation that Ms. Balada had the requisite work experience during the Audit Period or that Ms. Balada provided any services to Medicaid recipients.

61. Respondent submitted a document, dated November 25, 2019, related to Transportation America. This document does not verify dates of

employment and provided a statement that conflicts with documents obtained from Transportation America.

62. Similarly, the letter dated November 3, 2019, presumably from Ms. Balada, did not indicate work providing direct services to the target population.

63. Moreover, both the November 3, 2019, letter and the November 25, 2019, document were created post-hire, after Ms. Balada had ceased working for Respondent, after the end of the Audit Period, and after the PAR was issued. As such, both documents are unreliable, and neither document was contemporaneous as required by statute and rule.

64. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Balada met the requisite work experience at the time of hire, or at any point during the Audit Period.

65. With Ms. Balada's last date of work with Respondent being May 30, 2018, and her hire date being September 21, 2017, her work there did not provide the requisite work experience prior to the end of the Audit Period.

66. The unrefuted testimony substantiates that the overpayment attributable to claims billed by and paid to Respondent for Anaidys Balada is $61,900.82.

B. Elizabeth Lozano

67. The application for Elizabeth Lozano, provided to the Agency by Respondent, listed work experience as a certified nursing assistant ("CNA") with Maxim Home Health ("Maxim") from January 2000 to March 2017. There was no indication of work providing direct services to the target population or that Ms. Lozano provided any services to Medicaid recipients.

68. The résumé for Ms. Lozano provided to the Agency by Respondent listed work experience as an HHA with both Maxim and Ace Home Health. The application and her résumé conflict as to Ms. Lozano's role with Maxim.

69. The dates of employment provided for Maxim within the résumé conflict with, and were substantially shorter than, the dates provided on the

application, which draws into question the reliability of both documents. Further, after the PAR was received, Respondent advised the Agency there was a "typing error" regarding the dates of Ms. Lozano's employment with Maxim. The application was handwritten, however, so the testimony regarding a "typing error" is not credible.

70. The job description for Maxim, listed on Ms. Lozano's résumé, is identical to the job description listed by Ms. Balada for her position with A & A Home Care.

71. Respondent's documentation demonstrated Ms. Lozano attended an "RBT in-service," even though there was no documentation she possessed an RBT certification.

72. Respondent's submissions demonstrated Ms. Lozano was first screened for work with Medicaid recipients in February 2017 and, therefore, could not have lawfully provided direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities prior to this date.

73. Respondent's submissions also demonstrated Respondent billed for services performed by Ms. Lozano prior to the date listed as her hire date by Respondent.

74. Respondent sent additional documents to the Agency after receiving the PAR, but those submissions did not contain contemporaneous documentation that Ms. Lozano had the requisite work experience during the Audit Period.

75. Respondent submitted a document, which is undated, with information presumptively gathered from Maxim, although the author of this document is unclear. The document does not provide support that Ms. Lozano had the requisite work experience during the audit. This document is similar to a document submitted in support of Ms. Balada, which was created in November 2019.

76. Moreover, both the memo attempting to correct dates of employment, dated November 14, 2019, and the undated document appear to have been created post-hire; after Ms. Lozano ceased working for Respondent, after the end of the Audit Period, and after the PAR was issued. As such, neither document was contemporaneous as required by statute and rule.

77. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Lozano met the requisite work experience at the time of hire.

78. With Ms. Lozano's last date of work with Respondent being May 30, 2018, and her hire date being November 2, 2017, her work there did not provide the requisite work experience prior to the end of the Audit Period.

79. The unrefuted testimony substantiates that the overpayment attributable to claims billed by and paid to Respondent for Elizabeth Lozano is $16,383.36.

C. Maria Martinez

80. The application for Maria Martinez provided to the Agency by Respondent listed work experience as a secretary with "DGRASS" from "12/16" to "5/17," an HHA with Wonderfull, and a dispatcher at Truck USA. There is no indication she provided direct services to the target population or that any of the individuals that Ms. Martinez provided services to were Medicaid recipients.

81. The résumé for Ms. Martinez provided to the Agency by Respondent listed work experience as a "segretary" with Grassy Waters from December 2016 to March 2017, a BA assisted therapist with Respondent from November 2017 to "current," a "Nursery Assisten" at "Trusck USA" from January 2016 through October 2016, a "Nursery assitent" at Suky Health Care Services ("Suky") from July 2016 to December 2016 and a massage therapist from January 2013 to February 2014. There is no indication of work providing direct services to the target population for any of those jobs.

82. The résumé for Ms. Martinez is nearly identical in every regard, including misspellings, to the résumé for Yurina Carvajal, another rendering provider at issue in this audit (*see* ¶¶ 104-114). The following sections were identical: "Summary," "Skills," and "Activities and Honors." Under "Activities and Honors" each résumé states that "sometime I takrs [sic] care of two siseter [sic] a ten year old [sic] who is diagnossed [sic] with selective mustis and second of fourteen year of age tha [sic] her diagnosis is ADHD," although neither listed any private duty work and the only common place of employment was Suky, a company that did not provide services to children. Under "Experience," both assert to have worked at Suky at the same time as a "Nursery ASSITENT." Both assert to have training to be "Nuersy assisten" [sic].

83. The documents sent to the Agency by Respondent demonstrated Ms. Martinez was first screened for work with Medicaid recipients in February 2017 and, therefore, could not have lawfully provided direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities prior to this date.

84. The documents sent to the Agency by Respondent demonstrated Ms. Martinez was hired December 13, 2017; however, Respondent billed for services performed by Ms. Martinez prior to her hire date.

85. Respondent sent additional documents to the Agency after receiving the PAR, but those submissions did not contain contemporaneous documentation that Ms. Martinez had the requisite work experience during the Audit Period.

86. Respondent submitted a document, dated November 12, 2019, asserting that Ms. Martinez possessed experience providing services to the target population; however, it does not provide any support that Ms. Martinez provided any services to Medicaid recipients.

87. Additionally, Respondent provided a letter, dated November 12, 2019, which appears to have been signed by Ms. Martinez, providing information related to Ms. Martinez's experience. However, both the November 12, 2019, document, and the November 12, 2019, letter were created post hire, after Ms. Martinez ceased working for Respondent, after the end of the Audit Period, and after the PAR was issued. They do not contain contemporaneous documentation of qualifications to provide BA services as required by statute and rule. Accordingly, it is unclear who created these documents as Respondent did not provide any testimony as to their author.

88. Moreover, the November 12, 2019, letter indicates that Ms. Martinez omitted an HHA job at Wonderfull (April 2017 to February 2018) from her résumé. However, that information conflicts with her application, in which she alleged she worked at Wonderfull from July 2017 to September 2017. There is no indication of work providing direct services to the target population in that job, and it does not provide any support that Ms. Martinez provided any services to Medicaid recipients.

89. The records Respondent sent to the Agency after the PAR also contained a letter, purportedly created on November 3, 2017, from Reidel Yero regarding work by Ms. Martinez from February 2007 to August 2009.

90. The November 3, 2017, letter is surprisingly similar to several other letters submitted by Respondent after the PAR that purport to have been authored or created by different individuals.

91. The November 3, 2017, letter was not properly provided to the Agency when Respondent provided documents on December 21, 2017, in response to the Agency's records request. Respondent certified that all records Respondent possessed relevant to the audit were provided as of December 21, 2017. If Respondent had possession of this letter on December 21, 2017, as the date of the letter would appear to indicate, then the letter should have been provided in Respondent's December 21, 2017, submissions to the

Agency, and Respondent's failure to include this document greatly diminishes its reliability.

92. With Ms. Martinez's last date of work with Respondent being November 27, 2018, and her hire date being December 13, 2017, Ms. Martinez only had approximately one year of providing direct services to the target population by the end of the Audit Period. Therefore, the children receiving those services received treatment from an unqualified provider during that time.

93. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Martinez met the requisite work experience at the time of hire or by the end of the Audit Period.

94. The unrefuted testimony substantiates that the overpayment attributable to claims billed by and paid to Respondent for Maria Martinez is $74,602.80.

D. Violetta Espinosa

95. The application for Violetta Espinosa provided to the Agency by Respondent listed work experience as an assistant at All Lutheran Church Preschool from 2016 to 2017, and as an assistant at Sage Dental from 2001 to 2014. There was no indication of work providing direct services to the target population, and this does not provide any support that Ms. Espinosa provided any services to Medicaid recipients.

96. The résumé for Ms. Espinosa provided to the Agency by Respondent listed work experience as a behavior assistant with Respondent from January 2018 to November 2018, an assistant at All Lutheran Church Preschool from April 2016 to November 2017, and as a dental assistant at Sage Dental from February 2001 to May 2014. Ms. Espinosa listed very detailed descriptions of her work duties for each job; however, there was no indication of work providing direct services to the target population at Sage Dental.

97. Ms. Espinosa's résumé indicated that she assisted "children with special needs with homework and extracurricular activities"; however, given its reference to working for Respondent through November 2018, this document was necessarily created at some point after November 2018. It was created not only post-hire, but, likely, after Ms. Espinosa ceased working for Respondent, on or about October 31, 2018. As such, the document was not contemporaneous documentation as required by statute and rule.

98. The records provided by Respondent to the Agency during the audit did not contain any independent verification from All Lutheran Church Preschool for the dates of employment; work with the target population; or any indication that services were provided to Medicaid recipients.

99. The documents sent to the Agency by Respondent demonstrated Ms. Espinosa was first screened for work with Medicaid recipients in November 2017 and, therefore, could not have lawfully provided direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities prior to this date.

100. Respondent sent additional documents to the Agency after receiving the PAR, but those submissions did not contain contemporaneous documentation that Ms. Espinosa had the requisite work experience during the Audit Period.

101. Respondent submitted a document that appears to relate to Ms. Espinosa's work experience at Sage Dental; however, this document conflicts with records from Sage Dental and the documents submitted prior to the PAR. This letter does not verify dates of employment and did not ask about Ms. Espinosa's experience with either the target population or Medicaid recipients. As such, it does not provide any support that Ms. Espinosa possessed the requisite work experience.

102. Dated November 22, 2019, the document was created post hire, after Ms. Espinosa ceased working for Respondent, after the end of the Audit

Period, and after the PAR was issued. As such, the document was not contemporaneous documentation as required by statute and rule.

103. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Espinosa met the requisite work experience at the time of hire.

104. The documents sent to the Agency by Respondent demonstrated Ms. Espinosa was hired December 15, 2017, but only began providing BA services on January 15, 2018, and ceased work for Respondent on October 31, 2018. As such, Ms. Espinosa only had approximately nine and one-half months of providing direct services to the target population at the end of the Audit Period. Therefore, the children receiving those services received treatment from an unqualified provider during that time.

105. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Espinosa met the requisite work experience at the time of hire or by the end of the Audit Period.

106. The unrefuted testimony substantiates that the overpayment attributable to claims billed by and paid to Respondent for Violetta Espinosa is $36,765.04.

E. Yurina Carvajal

107. The application for Ms. Carvajal provided to the Agency by Respondent listed work experience as an HHA with United Home Care from January 10, 2010, to December 18, 2017. There was no indication of work providing direct services to the target population for that job or that services were provided to Medicaid recipients.

108. The résumé for Ms. Carvajal provided to the Agency by Respondent listed work experience as a "Nursey Assisten" [sic] with Respondent from August 2017 to current, a "BA Assisted" therapist with Respondent from September 2017 to "current," a "Nursey Assisten" with United Home Care from January 2010 to July 2016, and a Nursery Assistant at Suky from July 2016 to December 2016. There was no indication of work providing

direct services to the target population or that services were provided to Medicaid recipients.

109. The résumé for Ms. Carvajal is nearly identical in every regard, including misspellings, to the previously discussed résumé for Ms. Martinez, another rendering provider at issue in this audit. The following sections were identical: "Summary," "Skills," and "Activities and Honors." Under "Activities and Honors" each writes that "sometime I takrs [sic] care of two siseter [sic] a ten year old [sic] who is diagnossed [sic] with selective mustis and second of fourteen year of age tha [sic] her diagnosis is ADHD," although neither listed any private duty work and the only common place of employment was Suky. Under "Experience," both claim to have worked at Suky, which, as mentioned above, does not provide services to children, at the same time as a "Nursery ASSITENT." Both claim to have training to be "Nuersy assisten" [sic].

110. There are inconsistencies between Ms. Carvajal's application and résumé. On her application, she listed her work at United Home Care as an HHA. On her résumé, she listed her work with United Home Care as a "Nursey Assiten." In addition, the alleged dates of employment are different.

111. The documents sent to the Agency by Respondent demonstrated Ms. Carvajal was hired November 9, 2017, but only began providing BA services on December 1, 2017, and ceased work for Respondent on November 30, 2018. As such, Ms. Carvajal only had approximately one year of providing direct services to the target population at the end of the Audit Period, thus the children receiving those services received treatment from an unqualified provider during that time.

112. Respondent sent additional documents to the Agency after receiving the PAR, but those submissions did not contain contemporaneous documentation that Ms. Carvajal had the requisite work experience during the Audit Period.

113. The document dated November 19, 2019, was created post hire, after Ms. Carvajal ceased working for Respondent, after the end of the Audit

Period, and after the PAR was issued. As such, it is not contemporaneous documentation as required by statute and rule.

114. Upon request from the Agency, Suky provided the Agency a document that directly contradicts the information provided by Ms. Carvajal and Respondent. Contrary to Ms. Carvajal's claims on her résumé that she was a "Nursey Assiten," Suky indicated she was an HHA and that Suky did not provide services to children. Suky further advised that it did not provide direct services to persons with mental health disorders, developmental or intellectual disabilities.

115. The records provided by Respondent to the Agency during the audit failed to demonstrate that Ms. Carvajal met the requisite work experience at the time of hire or by the end of the Audit Period.

116. The unrefuted testimony substantiates that the overpayment attributable to claims billed by and paid to Respondent for Yurina Carvajal is $74,139.58.

VII. Audit Ultimate Conclusions of Fact

117. In this case, the Agency presented credible, persuasive evidence establishing that the audit giving rise to this proceeding was properly conducted. The Agency obtained and reviewed records from Abella Yose, issued a PAR, reviewed additional records submitted after the PAR, issued the FAR, and, even then, continued to accept and review records, giving Abella Yose the benefit of the doubt whenever possible.

118. In this audit, the Agency examined the records provided by Abella Yose to determine whether maintained records establishing that its rendering providers met the qualifications set forth in the BA Coverage Policy. The BA Coverage Policy required no special documentation.

119. Abella Yose, as a Medicaid Provider and subject to the Medicaid statutes and rules, was required to keep contemporaneous records regarding entitlement to payment, including employment eligibility, and compliance with all Medicaid rules, regulations, handbooks, and policies. Abella Yose

failed to provide the Agency with documentation that the five rendering providers at issue in this proceeding met the qualifications set forth in the BA Coverage Policy.

CONCLUSIONS OF LAW

120. DOAH has jurisdiction over the subject matter and the parties to this action pursuant to sections 120.569 and 120.57(1), Florida Statutes (2020).

121. The Agency bears the burden of proof, by a preponderance of the evidence, that Respondent was overpaid by Medicaid for the claims billed. *See S. Med. Servs., Inc. v. Ag. for Health Care Admin.*, 653 So. 2d 440, 441 (Fla. 3d DCA 1995) (per curium); *Southpointe Pharm. v. Dep't of HRS*, 596 So. 2d 106 (Fla. 1st DCA 1992).

122. Section 409.913(11) provides the following:

> The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

123. As set forth in paragraph 33 above, the requirements to qualify as a behavior assistant under the Agency's BA program are set out in Section 3.2 of the BA Coverage Policy, October 2017, incorporated by reference. Fla. Admin. Code R. 59G-4.125. The only issue regarding the five of Respondent's behavior assistants subject to these proceedings is whether the Agency has proven the five did not "have at least two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities."

124. The experience qualification at issue here leaves many ambiguities and fails to define key terms. For example, the requirement as written does not specify: (1) whether the service has to be full time or part time; (2) whether non-paid or volunteer work counts toward the two-year

experience requirement; or (3) a certain minimum number of hours of experience per day, per week, per month, per year, or in total over the two years necessary to qualify. Further, the two-year experience requirement as written does not define the term "direct service."

125. Neither this rule nor any law, regulation, rule, or handbook provision requires that the work experience for behavior assistants must involve prior work with children or individuals under 21 years old. Agency witnesses took disparate positions on this issue. Agency witness, Ms. Olmstead, admitted that the qualifying experience "isn't required to be only with children." Agency witness, Ms. Dewey, cited Section 2.2 of the Handbook, regarding "Who Can Receive" services under AHCA's BA services program, which is in a completely distinct section from Section 3.0 of the BA Coverage Policy, describing provider eligibility. That section in general, and Section 3.2 of the BA Coverage Policy in particular, contains no requirement that the "two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities" must be with individuals under the age of 21. The Agency's attempt to impose the under-21 requirement for any of the five behavioral assistants is not found in the governing statutes or rules of the Agency and, therefore, cannot be deemed a prerequisite for providing services here.

126. The admitted evidence shows that here, as was the Agency's practice prior to 2018, each of the five rendering providers at issue was approved and assigned a provider number after she submitted an attestation "certifying that ... she met the requirements for enrollment." The Agency assigned the Abella Yose rendering providers Medicaid numbers during the time the Agency was approving provider participation based on "attestations from the applicant certifying that he or she met the requirements for enrollment," and prior to the Agency implementing "enhanced enrollment practices," such that "applications now require documentation of qualifications." However, in a de novo proceeding, such as this one, evidence that the five behavioral assistants

at issue made false attestations or that, upon discovery and further review, the statements made with respect to applicable qualifications to provide service were patently false, are fair game for charges and proof. The fact is that, in 2018, as part of the Agency changes to enrolling rendering providers--changes made after the five Abella Yose rendering providers at issue here were enrolled--the Agency began "requiring applicants to offer evidence to support their enrollment." The evidence is clear that the 2018 Agency requirements that applicants for enrollment as rendering providers supply "documentation of qualifications" with their application or "offer evidence to support their enrollment" at the time of their application did not apply at the time all five Abella Yose rendering providers at issue here were enrolled as behavioral assistants. However, in this de novo proceeding, the discovery that the alleged "qualifications" of the five providers were false when made and remained false throughout the pendency of these proceedings cannot be ignored. Untrue or false material statements made in an application for licensure can serve as the basis for discipline of a license, including suspension or revocation. The fact that, in 2017, the Agency accepted the applicants' attestations as true does not relieve the provider of its obligation to use qualified individuals to provide care reimbursed under the Medicaid program.

127. Moreover, despite the harsh rhetoric in Respondent's "closing argument" contained in its Proposed Recommended Order regarding "disastrous implementation of the Agency's Behavior Analysis program"; that the Agency "views all BA service providers with suspicion"; and that the Agency "takes a particularly dark view of South Florida BA providers, and saves a special disdain for Spanish-speaking providers," not a single witness was called by Respondent to explain why they accepted as true the false statements in résumés regarding the five individuals hired. Further, not a single witness testified that Respondent was somehow able to employ 22 of the 27 behavioral analysts on staff without violating the experience

requirement. Finally, not a single witness testified nor was evidence provided by Respondent as to why Abella Yose employed five legally unqualified behavioral assistants when they were able to employ 22 who met the statutory and rule requirements to be service providers. Instead, Respondent focused its blame on the Agency, forcefully arguing, incorrectly, that Abella Yose's five rendering providers, who were serving as behavioral assistants, "had at least two years of experience providing direct service to recipients with mental health disorders, developmental or intellectual disabilities."

128. Pursuant to section 409.920(2)(a), a person may not:

> 1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.
>
> 2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
>
> * * *
>
> 6. Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider.

129. Providing false information about the qualifications of five of Respondent's behavioral assistants subjects Respondent to sanctions by the Agency. The fact that an administrative proceeding was brought, merely to recoup the amount of money reimbursed for care given by unqualified providers, rather than taking criminal action against Respondent, does not forgive Respondent for using obviously unqualified individuals to provide BA services to Medicaid recipients.

130. Without providing authority, other than accusations by Respondent's counsel that Abella Yose is not subject to a demand for reimbursement

because it was not required to provide "proof" of its employees' qualifications under the law and rules of the Agency, does not forgive its false claims for reimbursement for unqualified providers. The cold, hard facts of this matter are that the five behavioral assistants under review here were not legally qualified to provide the services for which they billed. Based upon the discussion set forth in the Findings of Fact above, the five individuals were not legally qualified to provide any level of BA services, based upon the false experiences they (or Respondent on their behalf) listed in their résumés both at the time they were hired by Respondent and as of the date of the hearing when Respondent was first called to answer for its hiring of unqualified individuals to provide Medicaid services.

131. The Agency may rely on the audit records and reports submitted by Respondent, and the Agency's determination must be made based "solely upon contemporaneous records." § 409.913(21), (22), Fla. Stat. *See Ag. for Health Care Admin. v. HCR Manor Care Servs. of Fla., LLC*, Case No. 18-1848MPI (Fla. DOAH Mar. 7, 2019, p. 36, ¶ 107; Fla. AHCA Apr. 19, 2019).

132. "AHCA can make a prima facie case by proffering a properly supported audit report, which must be received into evidence." *Ag. for Health Care Admin. v. Hospice of the Fla. Suncoast*, Case No. 18-0492MPI (Fla. DOAH May 31, 2019, p. 57, ¶ 206; Fla. AHCA July 23, 2019); *See also Disney Med. Equip., Inc. v. Ag. for Health Care Admin.,* Case No. 05-2277MPI (Fla. DOAH Apr. 11, 2006, pp. 13-14, ¶ 24; Fla. AHCA May 31, 2006); *Colonial Cut-Rate Drugs, Inc. v. Ag. for Health Care Admin.*, Case No. 03-1547MPI (Fla. DOAH Mar. 14, 2005; Fla. AHCA May 27, 2005); *Full Health Care, Inc. v. Ag. for Health Care Admin.*, Case No. 00-4441 (Fla. DOAH June 25, 2001; Fla. AHCA Oct. 4, 2001).

133. The Agency's FAR, supported by the audit work papers, was received into evidence without objection, and establishes the Agency's prima facie case of the overpayment. *See* Pet'r Ex. 7; § 409.913(22), Fla. Stat.

134. Respondent failed to rebut the Agency's prima facie case, and section 409.913(22) "heightens the provider's duty of producing evidence to rebut the Agency's prima facie case, by requiring the provider come forward with written proof to rebut, impeach, or otherwise undermine AHCA's statutorily authorized evidence; it cannot simply present witnesses to say that AHCA lacks evidence or is mistaken." *Disney Med. Equip., Inc.*, Case No. 05-2277MPI, at p. 14, ¶ 25.

135. It is not the Agency's burden to prove a negative, i.e., it is not the Agency's burden to prove that the rendering providers at issue were affirmatively not qualified. It is the Agency's burden to prove that Respondent failed to provide the Agency contemporaneous documentation that the rendering providers at issue affirmatively possessed the qualifications necessary to provide services to Medicaid recipients, because it is Respondent's affirmative, statutory duty to ensure that claims are true and accurate and documented contemporaneously. *See Ag. for Health Care Admin. v. Island Ret. Home, Inc.*, Case Nos. 97-004270 and 97-004795 (Fla. DOAH July 17, 1998, pp. 49-50, ¶ 54; Fla. AHCA Oct. 8, 1998) (finding that AHCA demonstrated a violation of a rule, which requires administrators and staff to meet certain training requirements based on the fact that the provider produced no training records and no documentation showing that the training requirements had been met; Island Retirement also found rule violations for other instances of failures to document its entitlement to Medicaid payment).

136. If this tribunal is unable to affirmatively determine whether the rendering providers at issue possessed the legal qualifications to provide BA services based on the contemporaneous documentation submitted by Respondent, then the Agency has met its burden in this case.

137. Pursuant to section 409.913, Petitioner is authorized to recover Medicaid overpayments from Medicaid providers. The Agency presented credible, clear and convincing, evidence establishing that the audit was

properly conducted. Based on this evidence, the undersigned determines that the audit was properly conducted.

138. Pursuant to its authority under section 409.913, the Agency audited Respondent's records by analyzing the documentation Respondent submitted supporting its Florida Medicaid claims during the Audit Period, to determine whether payments were accurate.

139. The statutes, rules, and handbooks in effect during the period for which the services being audited were provided apply in a proceeding in which Petitioner seeks to recover an overpayment of Medicaid claims. *See Toma v. Ag. for Health Care Admin.*, Case No. 95-2419 (Fla. DOAH July 26, 1996; Fla. AHCA Sept. 24, 1996).

140. A provider's failure to document, in accordance with Medicaid handbooks and the Provider Enrollment Agreement, whether its rendering providers met the criteria to provide services, as stated in the promulgated handbook, is inconsistent with generally accepted business practices. *See Ag. for Health Care Admin. v. Hour Bliss*, *Inc.*, Case No. 19-6584MPI (Fla. DOAH Apr. 27, 2020, p. 28, ¶ 122; Fla. AHCA June 9, 2020); *Ag. for Health Care Admin. v. Zenith Psych. Servs.*, *Inc.*, Case No. 19-3666MPI (Fla. DOAH Jan. 14, 2020, p. 12, ¶ 28; Fla. AHCA Feb. 12, 2020).

141. Section 409.913(9) states that a:

> Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours.

142. Respondent, as a Medicaid provider, is responsible for retaining contemporaneous records, which substantiate the claims billed to the Medicaid program, including the qualifications of rendering providers employed by Respondent to perform the services claimed.

143. The failure of a Medicaid provider to document that its employees meet the applicable qualifications to provide services in accordance with the applicable Medicaid handbooks and the Provider Enrollment Agreement is inconsistent with generally accepted business practices. *See Zenith Psych. Servs.*, Case No. 19-3666MPI at p.12, ¶28. The Agency should not be prejudiced because Respondent failed to perform its due diligence during the hiring process and, consequentially, contemporaneous documentation of an individual's experience is no longer obtainable.

144. When presenting a claim for payment, a provider has an "affirmative duty," pursuant to section 409.913(7), to "supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate … ."

145. Section 409.913(7)(e) and (f) requires billing providers to have documents regarding entitlement to payment, including provider eligibility, and to comply with all Medicaid rules, regulations, handbooks, and policies, and because this is an audit and not an investigation, the documents submitted by Abella Yose were assessed at face value.

146. Section 409.913(7) (e) and (f) requires providers to present claims for reimbursement in accordance with all Medicaid rules, regulations, and handbooks, and to appropriately document all goods and services provided. The Medicaid rules and handbooks applicable to all Medicaid providers, and the Non-Institutional Medicaid Provider Agreement signed by Respondent set forth the type of documentation required to be kept. No specialized documentation was required by the BA Coverage Policy or requested in this audit.

147. Section 409.913(22) states: "[t]he audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Consistent with this provision, Petitioner can establish a prima facie case of overpayment by proffering a properly supported audit

report, which must be received in evidence. *See Colonial Cut-Rate Drugs, Inc.*, Case No. 03-1547MPI; *Full Health Care, Inc.*, Case No. 00-4441.

148. Petitioner presented documentary and testimonial evidence that supports the denial of the claims at issue in this proceeding. Abella Yose was required to keep contemporaneous records regarding entitlement to payment, including employment eligibility, and compliance with all Medicaid rules, regulations, handbooks, and policies. Abella Yose failed to provide the Agency with contemporaneous documentation that its rendering providers met the qualifications set forth in the BA Coverage Policy before or by the end of the audit.

149. Respondent's assertions that the Agency failed to follow an unspecified process to affirmatively determine the qualifications of any individual rendering provider are without merit and are not a defense to the Agency's audit. The issuance of a Medicaid provider identification number by the Agency does not eliminate a provider's obligation to verify that its rendering providers meet the eligibility requirements. *See Ag. for Health Care Admin. v. Advanced Behavioral Ass'n, LLC,* Case No. 19-3229MPI (Fla. DOAH Nov. 20, 2019, p. 13, ¶ 39; Fla. AHCA Jan. 3, 2020).

150. The "Who Can Provide Services" section (pp. 1-2) of the 2012 Florida Medicaid Provider General Handbook states:

> Only health care providers that meet the conditions of participation and eligibility requirements and are enrolled in Medicaid may provide and be reimbursed for rendering Medicaid-covered services.

The rule requires both eligibility and enrollment in Medicaid (i.e., a Medicaid number).

151. Based on these standards and the foregoing Findings of Fact, Petitioner proved, by a preponderance of the evidence, that Respondent was overpaid a total of $263,791.60 for claims that failed to comply with the laws, rules, and regulations governing Medicaid providers.

152. The unrefuted testimony and evidence demonstrated that Respondent did not provide any documentation, let alone contemporaneous documentation, indicating that any of the rendering providers at issue had two years providing direct diagnostic or treatment procedures to an individual enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities before, or by the end of, the Audit Period.

153. Respondent's documentation does not even assert that any of the five rendering providers at issue provided diagnostic or treatment procedures to individuals enrolled in Florida Medicaid with mental health disorders, developmental or intellectual disabilities.

154. The AHCA screening dates indicate when a rendering provider was cleared to work with Medicaid recipients and can be used to infer whether an individual provider was previously screened by Medicaid to provide services to developmentally disabled Medicaid recipients.

155. Any willingness of the Agency to consider services to "children with mental health disorders, developmental or intellectual disabilities," regardless of their Medicaid status, does not create an un-promulgated rule because Agency consideration of experience providing services to non-Medicaid recipients is more inclusive than the rule's requirements, thus benefitting Respondent and not substantially harming or adversely affecting it. *See* §120.542, Fla. Stat. (re waiver or variance of a rule when application would create a substantial hardship and the purpose of the statute can be achieved by alternative means).

156. Petitioner's willingness to be more inclusive in trying to find the rendering providers at issue to be qualified is not an un-promulgated rule. The seminal case interpreting and addressing at what point an agency policy statement constitutes a rule which must be duly promulgated as such by the agency, is *McDonald v. Department of Banking and Finance*, 346 So. 2d 569 (Fla. 1st DCA 1977), appeal after remand, 361 So. 2d 199 (Fla. 1st DCA

1978), *cert. denied*, 368 So. 2d 1370 (Fla. 1979). In *McDonald*, the First District Court of Appeal stated: "rulemaking procedures are imposed only on policy statements of general applicability, i.e., those statements which are intended by their own effect to create rights, or to require compliance, or otherwise to have the direct and consistent effect of law." *Id.*, 346 So. 2d at 581.

157. As such, a rule consists of two necessary components: a rule must be a statement of general applicability; and the statement must implement, interpret, or prescribe law or policy or describe the procedure or practice requirements of an agency. *See Ag. for Health Care Admin. v. Custom Mobility, Inc.*, 995 So. 2d 984, 985 (Fla. 1st DCA 2008).

158. Florida courts interpreting section 120.52(16) have further developed a two-prong analysis used to determine what constitutes an unadopted rule. First, regarding the general applicability factor, the courts have held that a statement is not of general applicability if it is applied on a case-by-case basis or only under certain circumstances. *See id.* at 986. Second, courts have held that only those statements which "are intended by their own effect to create rights, or to require compliance, or otherwise to have the direct and consistent effect of law" constitute a "rule" pursuant to section 120.56(16). *Id.*

159. Finally, prior to discussing the penalty to be imposed in this matter, the undersigned feels compelled to address a statement by Respondent in its "closing argument" contained in his post-hearing submittal. The statement found on page six of Respondent's Proposed Recommended Order reads "[t]o be sure, the evidence establishes the Agency views all BA service providers with suspicion, takes a particularly dark view of South Florida BA providers, and saves a special distain for Spanish-speaking providers." No evidence whatsoever was presented at hearing that the Agency or its employees exhibited prejudice against South Florida BA providers or Spanish-speaking providers. With the huge population of Spanish-speaking providers of Medicaid and other health services in South Florida, the Agency, in fact,

deals with Spanish-speaking providers on a daily basis. Without evidence to the contrary, the undersigned refuses to impugn either the Agency or an entire group of providers, most of whom are never cited or investigated by the Agency for improper reimbursements, based upon non-evidence-based innuendo in this single case. The accusation here is based upon one statement from Ms. Olmstead, a witness for the Agency in which she said, when asked why she did not bother to call a specific Abella Yose rendering provider, that "based on the quality of the applications for most of them, they wouldn't have been able to speak to me in English." As set forth in paragraphs 108 through 110 above, several of the résumés submitted by Respondent for the behavior assistants were so lacking in grammar, syntax, and spelling, that such a conclusion could be made about those identified individuals, but not about the entire Spanish-speaking population of South Florida.

160. In this matter, Petitioner is authorized to impose sanctions as appropriate. *See* § 409.913(16), Fla. Stat. The 2010 version of rule 59G-9.070, "Administrative Sanctions on Providers, Entities, and Persons," was in effect during the Audit Period, and applies to this proceeding.

161. To impose a fine, Petitioner must establish the factual grounds for doing so by clear and convincing evidence. *See Dep't of Child. & Fams. v. Davis Fam. Day Care Home*, 160 So. 3d 854, 857 (Fla. 2015). The Agency presented unrefuted, credible, competent and substantial testimony that Respondent provided additional documentation created after the PAR was issued. Therefore, the Agency demonstrated its entitlement to sanctions by clear and convincing evidence in this proceeding.

162. The sanction under rule 59G-9.070(7)(c) applies because Respondent provided documentation after the PAR that was not included in Respondent's initial response to the Agency's demand for records. Petitioner is entitled to a sanction of $2,500.00 pursuant to rule 59G-9.070(7)(c), and also a sanction of $52,758.32 pursuant to rule 59G-9.070(7)(e).

163. Pursuant to section 409.913(23), as the prevailing party in this proceeding, Petitioner is entitled to recover, as costs, all investigative, legal, and expert witness costs. At the time Petitioner issued the FAR, it was seeking costs in the amount of $528.00. Additional costs have been incurred in preparing for and attending the final hearing and filing post-hearing submittals.

RECOMMENDATION

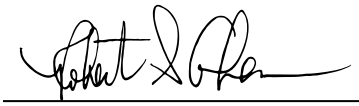
Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order finding:

1. That the Agency has established by a preponderance of the evidence that it overpaid Respondent the sum of $263,791.60 and that Respondent must reimburse the Agency for those payments;

2. That the Agency has proven by clear and convincing evidence that it is entitled to a sanction of $2,500.00 pursuant to rule 59G-9.070(7)(c), and a sanction of $52,758.32 pursuant to rule 59G-9.070(7)(e) (capped at 20 percent of the amount of the overpayment), for a total sanction of $55,258.32, to be paid by Respondent; and

3. That, pursuant to section 409.913(23), the Agency, as the prevailing party in this proceeding, is entitled to recover costs, from Respondent, including all investigative, legal, and expert witness costs as the prevailing party. As of the time of the FAR, the amount of these costs was $528.00. The final amount of costs will be determined in a subsequent proceeding to include costs incurred since issuance of the FAR. The undersigned hereby reserves jurisdiction regarding the final amount of costs, and, if the amount of the costs cannot be resolved between the parties, the Agency may request a hearing solely to establish the amount of the costs to be awarded.

DONE AND ENTERED this 3rd day of February, 2021, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

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