STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

POSITIVE BEHAVIOR SUPPORT,

Petitioner,

vs. Case No. 21-2714RP

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_______________________________________/

FINAL ORDER

Pursuant to notice, the final hearing on this matter was conducted on October 6 and 7, 2021, in Tallahassee, Florida, and via Zoom video conference before Robert S. Cohen, an Administrative Law Judge ("ALJ") with the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: William D. Hall, III, Esquire
Jordane Wong, Esquire
Dean Mead and Dunbar
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

For Respondent: Bradley S. Butler, Jr., Esquire
Timothy P. Sparks, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Shena L. Grantham, Esquire
Agency for Health Care Administration
Building 3, Room 3407B
2727 Mahan Drive
Tallahassee, Florida 32308

STATEMENT OF THE ISSUE

Whether proposed subsection (3)(b)3. of Proposed Florida Administrative Code Rule 59G-4.132 ("Proposed Rule") is an invalid exercise of delegated legislative authority.

PRELIMINARY STATEMENT

Respondent, Agency for Health Care Administration ("AHCA," "Agency," or "Respondent"), has proposed an amendment to the language of the Proposed Rule. Petitioner, Positive Behavior Support ("PBS" or "Petitioner"), timely requested an administrative hearing pursuant to section 120.56(1) and (2), Florida Statutes, alleging that subsection (4) of the Proposed Rule was an invalid exercise of delegated legislative authority. The matter was filed with DOAH on September 8, 2021, to conduct a final hearing, and the matter was assigned DOAH Case No. 21-2714RP.

The Agency filed a Motion to Dismiss the Petition which was denied. Subsequent to the scheduling of the hearing, the Agency issued a Notice of Change, altering the language in the Proposed Rule to that under consideration now. Following the Notice of Change, Petitioner filed an amended petition amending its challenge from subsection (4) of the Proposed Rule to subsection (3)(b)3., pursuant to the latter section's adjustment within the Notice of Change. On September 15, 2021, this matter was scheduled for hearing to occur on October 6 and 7, 2021, with the ALJ, counsel for both parties, and the Agency's representative to be present in Tallahassee, Florida, while the other witnesses from South Florida were to appear via Zoom video conference.

As directed by the September 15, 2021, Order of Pre-hearing Instructions, the parties filed a Joint Prehearing Stipulation. Additionally, Petitioner filed a Motion for Summary Final Order, and Respondent filed a Motion in Limine

to Exclude Evidence. Both matters were heard at the beginning of the hearing on October 6, 2021.

After hearing from the parties, the undersigned denied Petitioner's motion and reserved ruling on Respondent's motion, stating that testimony and evidence regarding the Agency's current practices would be heard and reserving the decision as to whether such testimony and evidence would be considered. Thereafter, the hearing commenced.

The parties offered Joint Exhibits 1 through 8 into evidence without objection. Petitioner offered Exhibits 1 through 22 into evidence, subject to the Agency's relevance objections to Petitioner's Exhibits 1 through 4 and 11 through 22 as stated in both the Joint Prehearing Stipulation and the motion in limine. The Agency offered Exhibits 1 through 14 into evidence, subject to Petitioner's "bolstering" objections to Exhibits 1 and 2. The Tribunal accepted all exhibits into evidence and reserved ruling on the parties' objections.

AHCA presented live testimony from the Agency's representative, Melissa Vergeson, bureau chief of the Agency's Bureau of Medicaid Quality. The Agency also presented the testimony of Kelly A. Bennett, chief of the Agency's Bureau of Medicaid Program Integrity, by Zoom video conference.

PBS presented testimony by Zoom video conference of Daniel Black, its corporate representative and PBS's director of Medicaid services; Krystal Lexima, owner of Bridges Behavioral Therapy; and Diane Donahue, co-owner of Treasure Coast ABA.

At the conclusion of the hearing, the parties agreed to file proposed final orders no later than ten days after the transcript was filed with DOAH, reserving the possibility of extending the deadline on mutual agreement. The

Agency then renewed its request for a ruling on its Motion in Limine to Exclude Evidence. The undersigned stated its ruling would be issued at a later date.

The Transcript of the final hearing was filed on October 18, 2021, making the proposed final orders due on October 28, 2021. The parties timely filed their proposed final orders.

All statutory citations will be to the 2019 version of the Florida Statutes, unless otherwise indicated.

FINDINGS OF FACT

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." The Agency is responsible for administering the Florida Medicaid program in accordance with state and federal law.

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," pursuant to section 409.913, Florida Statutes.

3. PBS is a provider of applied behavior analysis ("BA") services to the Medicaid program. It provides those services pursuant to a voluntary Medicaid Provider Agreement ("Provider Agreement") with the Agency. PBS plans to continue offering such Medicaid services for the foreseeable future.

4. The Proposed Rule will regulate providers of Medicaid BA services if/when it takes effect.

5. BA is an optional Medicaid service that is often associated with and utilized by those with autism or other developmental disabilities.

Factual Testimony from the Parties

6. Melissa Vergeson is bureau chief of Medicaid Quality. Ms. Vergeson has worked for the State of Florida since 1997 and has held positions for the Florida Department of Health, the Florida Department of Elder Affairs, and several positions with Respondent. Ms. Vergeson is tasked with monitoring health plan performance to make sure that plans are providing services that their members need and in a timely manner.

7. Kelly Bennett is bureau chief of Medicaid Program Integrity ("MPI"). Ms. Bennett is a member of the Florida Bar, has worked for the State of Florida since 1997, and for the Agency since 2001. Ms. Bennett has worked with Medicaid fraud issues in her previous roles with the Agency since 2002 and has worked with or for MPI for approximately 20 years.

8. Daniel Black is the corporate representative and director of Medicaid services for Petitioner.

9. Krystal Lexima provided testimony at the request of Petitioner and is the owner of Bridges Behavioral Therapy. Neither she nor her Medicaid provider company filed a rule challenge or petition to intervene in this matter, or otherwise attempted to achieve party status.

10. Diane Donahue provided testimony at the request of Petitioner and is the co-owner of Treasure Coast ABA. As was the case with Ms. Lexima, neither she nor her Medicaid provider company filed a rule challenge or petition to intervene in this matter, or otherwise attempted to achieve party status.

11. Ms. Bennett testified that MPI is the program required under federal law to "address fraud and abuse and what we more commonly refer to as program integrity."

12. The parties conduct business pursuant to the terms of the Provider Agreement, which requires Petitioner to comply with all Medicaid rules, statutes, and law.

13. Petitioner is presently a provider of Medicaid Services, operating pursuant to a Provider Agreement.

14. The Provider Agreement is a voluntary contract between the Agency and the provider. An enrolled Medicaid provider must comply fully with all state and federal laws pertaining to the Medicaid program, including Medicaid Provider Handbooks incorporated by reference into rule, as well as all federal, state, and local laws pertaining to licensure, in order to receive payment from the Medicaid program.

15. Petitioner has executed a Provider Agreement and provides BA services to the Medicaid program pursuant to that agreement.

16. The Proposed Rule does not regulate the profession of BA. Instead, the Proposed Rule establishes requirements that providers of Medicaid services must follow to be reimbursed for the provision of BA services to Medicaid recipients. The provisions of the Proposed Rule do not apply to the practice of BA, and properly credentialed individuals may provide BA services to non-Medicaid patients within Florida without being required to submit to the requirements of the Proposed Rule.

17. Both Petitioner and the Agency may terminate Petitioner's Provider Agreement at any time, without cause. *Diaz v. Ag. for Health Care Admin.*, 65 So. 3d 78 (Fla. 3d DCA 2011). Petitioner has no expectation of continued participation in Medicaid. *Id.* at 82-83 (finding that despite being long-time providers to Florida Medicaid and expecting to continue participating, such expectation is not appropriate based on the statutory authority and case law).

<u>Historical and Present Fraud and Abuse from BA Providers</u>

18. The BA provider type has been a cause of significant fraud and abusive billing practices to the Medicaid program, as detailed in the Agency's

report to the Legislature titled "Florida's Efforts to Control Medicaid Fraud & Abuse, Fiscal Year 2018-2019."

19. After the Medicaid BA program launched, within the first few weeks, MPI began to witness incidents of fraud in isolated areas, and began to try to get a "lay of the land" of what was occurring within the BA program. After the Agency began to review the BA program, the Agency discovered what Ms. Bennett described as "the most pervasive fraud that I've ever seen in my 20 years."

20. Ms. Bennett testified at length regarding the issues of fraud and abuse that have occurred in the BA program. Ms. Bennett discussed discovering "folks that had no business in this business" and who had "lied on their applications." This was before even looking at whether services were actually delivered or delivered appropriately.

21. While the Agency has authority to recover overpayments, recovery is costly to the Agency, as it must spend significant resources recovering funds inappropriately paid for services that were not performed in accordance with the requirements of Medicaid. Each dollar that is retained because of a fraud prevention system becomes "a dollar that would have been lost that's now not lost, so we don't have to have the additional expense of going to chase after it."

22. Ms. Bennett testified that the Florida Medicaid Management Information System ("FMMIS") is simply a repository for claims information. All other functions are performed by a system that is built as an add-on to the FMMIS system. Specifically, "FMMIS itself is not like a fraud detection system or a fraud prevention system, it's a repository of information, and a system to pay claims."

23. Issues may arise when fraudulent claims are submitted to the system, given that those claims are still paid even if the claims were for "people working or children receiving more – more services, like units that would add up to more than 24 hours in a day." While FMMIS was updated to "not allow

claims that exceed 24 hours in a day," the system is limited in its functionality, including being unable to address "the greatest shortcoming of any claims processing system ... the inability to know if the services were rendered."

24. Any system that can interact with the claims system to increase the likelihood that submitted claims are valid and legitimate, like the electronic visit verification ("EVV") system proposed by the Proposed Rule, would be "a win from a fraud prevention standpoint." While EVV is an important tool for fraud prevention, it is not a magic wand that will either prevent all fraud or totally eliminate errors or inconvenient glitches, as Ms. Bennett testified, "[y]ou build systems, and build a program for the masses, who you presume will try to be legitimate, and then you try to build things that will make the most obvious illegitimate things denied." EVV helps because "just the ability to know that a service provider interacted with the recipient for the time period that the claim is being billed," is beneficial to preventing and deterring fraudulent and abusive billing, "particularly for services that are not typically rendered in a typical office setting."

25. Ms. Bennett testified to the extraordinary efforts that the Agency implemented to combat the pervasive fraud in the BA program, including the implementation of a moratorium on enrollment for BA providers, a mechanism that had never been used by the Agency previously and that required approval by the federal Centers for Medicare & Medicaid Services ("CMS").

26. Each of the provider witnesses who testified at hearing, Mr. Black, Ms. Lexima, and Ms. Donahue, agreed there was fraud and abuse in the area of Medicaid-reimbursed BA services, and that they were keenly aware of the issues of fraud and abuse permeating the BA industry in recent years.

27. EVV is one effective method of deterring fraud, and it "will take a burden off of us if it works," according to Ms. Donahue's testimony.

28. Mr. Black went a step further when he testified that Petitioner has used its own EVV system to catch its employees committing fraud, stating "we have turned them in."

The EVV System

29. In subsection (2)(a) of the Proposed Rule, the Agency defines EVV as:

> A process by which service encounters are electronically verified with respect to the type of service performed, the recipient receiving the service, the date of the service, the location of service delivery, the provider rendering the service, and the time the service begins and ends.

30. This comports with the federal definition of EVV at 42 U.S.C. § 1396b(1)(5)(A). This definition references "personal care services or home health services," but does not specifically reference BA services. With respect to BA services, the same holds true for the applicable provisions in the Florida Statutes, which will be discussed more fully below.

31. Despite the lack of such federal or state statutory requirement, PBS is a strong advocate for the use of EVV in all Medicaid services. In fact, in Florida and other states where PBS operates, it is already utilizing an internal EVV system to prevent and detect any fraud in the provision of its BA services. Utilizing this internal program, PBS has been able to catch some of its own employees attempting to commit fraud, and it has referred those persons to the proper authorities.

32. Therefore, PBS does not challenge the use of EVV generally. Rather, it specifically challenges the portion of the Proposed Rule requiring BA providers to submit Medicaid claims for processing and payment through the EVV system.

33. As a plain reading of both the Agency's proposed definition and the federal EVV definition shows, submitting claims for payment (or playing any

role in the payment of claims) is outside of the defined scope of EVV. The Agency did not present any evidence to the contrary.

34. Federal law and guidance also require states implementing EVV to ensure that their systems are "minimally burdensome" and to "take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders." *See* 42 U.S.C. § 1396b(l)(2)(A)(i) and (B).

35. CMS has issued EVV guidance to states in an effort to help ensure these systems are successful. One such piece of guidance is entitled "EVV Requirements in the 21st Century CURES Act," offered into evidence by PBS at hearing. In that guidance, CMS makes clear that it "is not endorsing any" particular home health EVV model or system discussed therein. It then identifies five different types of EVV system models that states have utilized. CMS then provides an overview of those system types, as well as some considerations pertinent to each one. Whatever model a state selects, CMS stressed the importance of soliciting feedback from providers, patients, and other effected persons.

36. One of those potential models is for a state to contract with a single external vendor to develop an EVV system that all providers must use. Although the Agency chose this model, it has provided no evidence to support the concept that utilizing such an external EVV vendor for billing purposes is an accepted or preferable practice. Further, as detailed below, the Agency cannot credibly contend that it gave any real consideration or weight to provider feedback in crafting this policy. The Agency also did not, and could not, argue that its system has been "minimally burdensome" to Florida Medicaid BA providers. As will be described below, it has been an extreme burden to them. Despite this and the universally negative feedback it has received from those affected, the Agency has refused to consider any change to its proposed EVV policy.

Claims Submission for BA Services

37. Pursuant to the Florida Reimbursement Handbook ("Reimbursement Handbook"), claims for payment for all Medicaid services may be submitted "directly to the Medicaid fiscal agent through the fiscal agent's secure web portal." This refers to submission of claims directly to FMMIS. This is the only permissible means of electronic claims submission listed in the Reimbursement Handbook. Submission directly to FMMIS "offers the advantage of speed and accuracy in processing" of claims and allows providers to "correct data entry errors immediately."

38. The Reimbursement Handbook also offers providers a recourse in the event there is an issue that prevents a claim from being paid. It states that providers "should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline." As discussed previously, the Reimbursement Handbook only contemplates submission of claims directly through FMMIS, meaning that any "resubmission" would occur through the same system. In the event of denial due to a "system error," the promulgated remedy within the Reimbursement Handbook is once again for providers to submit a new claim through FMMIS.

39. Mr. Black has been resubmitting and correcting claims through FMMIS for approximately 25 years. He provided testimony as to how that is accomplished easily and effectively pursuant to the provisions of the Reimbursement Handbook.

40. The Florida Medicaid Provider General Handbook ("Provider Handbook") defines a "billing agent" as "an entity that offers claims submission services to providers." It states further that "providers may submit claims themselves or choose to have a billing agent." The Reimbursement Handbook includes essentially the same provision. This is reasonable in that, if a provider contracts with a billing agent that is not

properly or timely submitting claims for payment, then the provider can replace them with another agent who can properly fulfill that essential task.

<u>The Agency's EVV System for BA Services and Its Impact</u>

41. In late 2019, the Agency entered into a contract with 4Tellus, LLC ("Tellus") (now known as "Netsmart"), to serve as the Agency's designated EVV system provider for Medicaid BA services. Pursuant to that contract, BA providers would be "allow[ed], but not require[d]" to use the EVV system in December 2019 "in order for claims to be submitted and paid." That practice would then become mandatory, at least for a portion of the state, in March 2020. After that point, all Medicaid BA providers "in the impacted regions" would be required "to use the Tellus system in order to submit claims and be paid."

42. According to Ms. Vergeson, the signing of that contract represents the point at which the Agency officially made the policy decision to utilize an external EVV vendor that would act as a mandatory billing agent for Medicaid BA services. When asked, in light of this contractual obligation, what any BA provider could have done or said to even potentially change this policy position during rulemaking, Ms. Vergeson responded, "I don't have an answer to that."

43. Before that contract was even signed, representatives of Tellus and PBS began to correspond regarding beta testing of the EVV system. David Graci, chief director of Business Processes for PBS, stated that the company would be happy to try the beta testing and to give Tellus a demonstration of its current EVV processes.

44. Mr. Black testified that, "very early on" in that beta testing process, it became "very apparent" to PBS that the EVV system had "significant problems" relating to claims submissions. PBS conveyed these concerns to the Agency "multiple times." In fact, problems escalated to the point where PBS,

Tellus, and Agency representatives were "meeting regularly at weekly meetings, biweekly meetings" for "many months."

45. The Agency did not change its policy course. Between September 2019 and February 8, 2021, the Agency permitted, but did not require, BA providers to submit claims for payment through the EVV system for all Medicaid services provided in Medicaid Regions 9, 10, and 11 ("Pilot Regions"). The Agency also permitted BA providers to submit claims for Medicaid services provided in the Pilot Regions directly to FMMIS (as discussed in the Reimbursement Handbook) during that time.

46. Since at least February 8, 2021, the Agency has imposed a non-rule policy requiring BA providers to submit all claims for Medicaid services provided in the Pilot Regions through the EVV system. BA providers have not been permitted to submit claims directly to FMMIS during that time period.

47. The EVV system has resulted in financial burdens to PBS and other providers since its implementation in the Pilot Regions. Specifically, it has altered claims, failed to properly submit claims to FMMIS (or submit them to FMMIS at all), and otherwise caused delays in payment and improper denial of Medicaid claims. At one point, things deteriorated to the point where an Agency representative gave PBS permission to bill straight to FMMIS again for a brief period of time. In one week in June of 2021, the EVV system improperly caused the denial of approximately $67,000 worth of PBS's claims. Early the following month, there was a point where more than 1,600 claims worth around $275,000 were delayed without justification. Due solely to the EVV system, PBS has had to devote an inordinate amount of time and resources trying to get its claims paid in the Pilot Regions. The time and stress devoted to this has caused Mr. Black, in his words, "significant issues professionally and personally."

48. Mr. Black testified that one of the major issues with the EVV system is its inability to handle a high volume of claims at once. This issue, in and of itself, has caused claims processing errors and delays. Based on this, PBS has

sometimes had to hold back submitting some claims or not submit claims on certain days to avoid overloading the system. This continuing problem leads Mr. Black to have “legitimate concerns” regarding how the EVV system will be able to process claims when it is expanded statewide and “the volume essentially doubles.”

49. Ms. Lexima is a board-certified behavior analyst who owns her own BA company. Her company is a provider of Medicaid BA services in Palm Beach County. Before the EVV system was implemented, she never had significant issues with Medicaid claims payment. However, since the EVV system was rolled out in the Pilot Regions, she has experienced significant payment issues. Ms. Lexima approximates that payment has been delayed for around 70 to 80 percent of her Medicaid claims since she began having to bill through the EVV system. This has caused her business such harm that she had to take out a loan to keep her business solvent. Ms. Lexima has also experienced significant confusion and issues regarding how to resubmit denied claims using the EVV system. Based on these issues, Ms. Lexima has had to consider limiting or capping the number of Medicaid patients she will treat.

50. Ms. Donahue is the co-owner of Treasure Coast ABA services in Palm Coast, Florida. Her company is a Medicaid BA provider in the Pilot Regions. Much like Ms. Lexima, she never experienced significant claims denial issues when billing directly to FMMIS. Since the EVV system was implemented in the Pilot Regions, however, her company has also seen approximately 80 percent of its claims improperly delayed or denied. This equates to approximately $35,000 in delayed or denied claims per week. Further, the company has had to hire additional staff to deal solely with the processing errors and issues resulting from the EVV system. To keep her business open, Ms. Donahue has had to take out a home-equity loan. Still, due purely to the EVV system, she and her business partner are “constantly” discussing whether their company can stay financially viable.

51. PBS and others have repeatedly made the Agency aware of these issues and financial injuries. The Agency concedes that the EVV system has caused at least many of these issues and that they are not the result of user error, fraud, or any other legitimate reason. In fact, the Agency did not present any evidence showing or suggesting that any of the payment delays or denials discussed in evidence were the result of anything other than issues with the EVV system itself.

The Proposed Rule

52. The Agency published the Proposed Rule's text in the Florida Administrative Register on August 9, 2021. Proposed subsection (4) of the Proposed Rule stated:

> Providers must submit claims through the designated EVV vendor's system for services rendered and verified in accordance with prior authorizations.

53. The clear intent of this proposal was to codify, and expand statewide, the current non-rule policy requiring BA providers to submit Medicaid claims through the EVV system. The Agency confirmed this in a written question-and-answer sheet published during rulemaking.

54. The Agency held a rulemaking workshop regarding the Proposed Rule on May 28, 2021. That workshop was strictly an online webinar and did not have any in-person attendees. The Agency did not publish any specific rule language before or at this workshop.

55. The Agency did not record or transcribe the comments that its representatives made at this workshop. However, it did make a spreadsheet including the written comments that virtual attendees submitted through the webinar. This spreadsheet reflects a number of critical comments regarding the EVV system and payment/processing issues stemming from it.

56. The Agency also received a number of written comments after the workshop regarding the EVV system's impact in the Pilot Regions. Although there were a few written comments that did not address the system directly, those that did universally decried it. A number of those comments mirrored Ms. Lexima's and Ms. Donahue's testimony, noting, in part, that:

> In [the Pilot Regions], providers have report[ed] devastating errors, glitches, and issues that have prevented them from being able to continue to provide services to Medicaid recipients or even forced them to close their doors due to the inability to receive accurate, consistent, and timely reimbursements.

57. They stated further, as Mr. Black testified, that the EVV system was already experiencing "load issues on a regular basis" and that expanding its use would "overload the system, furthering the negative impact on providers and Medicaid recipients." Therefore, those parties asked that the Agency "halt the expansion of the program" and discontinue its use.

58. The Agency held a rulemaking hearing regarding the Proposed Rule on August 30, 2021. By that time, the Agency had published the previously-mentioned original Proposed Rule text. That hearing was conducted as both an online webinar and an in-person meeting. There were in-person attendees for this hearing.

59. Ms. Donahue testified at the August 30, 2021, hearing. Others, who attended by electronic means, offered written comments. The comments were again critical of the Agency's proposed EVV policy.

60. Ms. Vergeson testified that the Agency considered all comments submitted during rulemaking. Petitioner disagreed with this statement, believing that the Agency's rulemaking activities were merely a "formality" and that the Agency had no intention of making any changes based upon attendees and other interested parties' critiques of the Proposed Rule.

61. However, on September 29, 2021, a Notice of Change regarding the Proposed Rule was published in the Florida Administrative Register. The language in that Notice of Change is the pertinent rule challenge for the purpose of this proceeding.

62. Proposed subsection (3)(b)3. of the Proposed Rule, which is the portion of the proposal that PBS is challenging, states:

> Providers who furnish home health or behavioral analysis services must submit claims through AHCA's designated EVV vendor's system to the Florida Medicaid fiscal agent for services rendered and verified in accordance with prior authorizations in the Florida Medicaid Management Information System. Neither a provider who furnishes home health or behavior analysis services, nor a billing agent of that provider, may submit claims directly to the Florida Medicaid fiscal agent irrespective of any other provision including, but not limited to, Rule 59G4.001, F.A.C.

63. Subsection (3)(b)3. replaced what was originally listed as subsection (4) of the Proposed Rule when it was first published.

64. If subsection (3)(b)3. of the Proposed Rule goes into effect, BA and home health providers will not be permitted to electronically submit Medicaid claims directly through FMMIS. Instead, they will be required to submit such claims through the EVV system, which then forwards those claims to FMMIS for processing and payment. But for this subsection, Medicaid BA providers would be permitted to bill directly to FMMIS, as discussed in the Reimbursement Handbook.

65. As discussed previously, this subsection will make the Agency's EVV system a mandatory billing agent for all Medicaid BA providers. Such providers may contract with an additional, optional billing agent to then submit their claims to this mandatory billing agent, if they wish. However,

Medicaid BA providers will have no choice regarding whether to submit claims through the EVV system.

66. Petitioner argues that this proposed policy does not account in any way for the provisions of the Provider Handbook or the Reimbursement Handbook permitting providers to choose their billing agents. Those policies, which the Agency has officially promulgated, do not even contemplate the idea of a mandatory billing agent. Although subsection (3)(b)3. of the Proposed Rule expressly exempts other rules which might permit a Medicaid provider to bill claims directly to FMMIS, it in no way acknowledges the conflicting provisions which expressly permit providers to choose whether they utilize a billing agent. There is no reasonable reading of this provision that can be squared with the Provider Handbook or the Reimbursement Handbook on that point. The question remaining is whether the Agency has statutory authority to make such a process mandatory.

67. Subsection (3)(b)3. also does not address how the resubmission or correction of claims would be addressed in the event (which the Agency has actual knowledge has occurred repeatedly) that the EVV system itself causes processing or payment issues. The Reimbursement Handbook provides that such a claim may be corrected and/or resubmitted through FMMIS. However, providers can no longer “submit” claims to FMMIS, making it unclear how they can “resubmit” claims there. In the event the EVV system itself causes such a problem, the Proposed Rule provides no remedy. Currently, a provider could simply replace an optional billing agent that is not fulfilling its duties. However, as previously stated, Medicaid BA providers will not have that option for the EVV system.

68. Mr. Black testified that, if the challenged section of the Proposed Rule went into effect, it is not clear to him from the rule language how resubmission or correction of claims would be accomplished. Although Agency and/or Tellus personnel have provided Mr. Black with an unofficial explanation of how this could occur, Mr. Black testified as to why the process

they described is nonsensical and “defeats the entire purpose of having an EVV system.”

69. The Agency said this should not be a concern by asserting that the Reimbursement Handbook would still apply. Ms. Vergeson testified that it is not reasonably possible for a provider to be confused as to how “resubmission” of claims to FMMIS is possible when they may not “submit” claims to FMMIS. Contrary to this assertion, it appears difficult, if not impossible, to make the challenged section of the Proposed Rule conform to the Reimbursement Handbook in this area. Petitioner fears that, through the adoption of the Proposed Rule, it has been placed in a precarious position, which leaves it unclear as to what their rights for submission and/or resubmission of claims will be going forward.

70. The Agency did not give a satisfactory response, at least to PBS’s way of thinking, as to why it decided to require that its EVV system serve as a mandatory billing agent. Ms. Vergeson testified simply, “it’s the model we chose.” When asked to expound on that, she stated that it “seemed the best model for the state of Florida given how our FMMIS operates, and limitations with how it can be changed or adapted.” The Agency did not elicit any evidence as to why this model works best with FMMIS or what limitations that system faces. The Agency representative added that having one single vendor allowed the Agency to “monitor that vendor much more carefully, and truly try and prevent and control fraud.”

71. The testimony offered by both the Agency and Petitioner at the hearing supports EVV as an effective tool to combat fraud. While the petition alleges that the EVV system has caused “delays in payment,” not even one specific instance of a payment delay correlated to a particular claim number was specified, although testimony from Mr. Black indicated, anecdotally and without documentary evidence to support the exact amount, that at least one payment delay lasted “less than two weeks.” This was supported by testimony from Petitioner’s witness, Ms. Lexima, who stated it took her

third-party billing company "maybe two business days" to figure out how to adjust their system and confirm it worked.

72. The Reimbursement Handbook, at page 2-2, states that "Claims are processed daily. Payments are made on a weekly basis. Under normal conditions, a claim can be processed from receipt to payment within 7 to 30 days." None of the witnesses testified that any claim was delayed greater than 30 days.

73. The petition makes no allegations of non-payment for validated claims. Petitioner's own witnesses concede that despite there being issues with payments being delayed, all claims have eventually been paid by the Agency. Mr. Black stated that "[e]ventually they did pay." Ms. Lexima stated, "they eventually figured it out." Additionally, she stated that, while she had to call to check in. "they just kind of worked what they had to do behind the scenes … eventually they were all resubmitted."

74. Petitioner concedes that the Agency has the legal authority to promulgate a rule that requires Medicaid providers to submit to EVV. Amended Petition, ¶ 38 (asserting that "[i]t is possible (in the event of a functioning EVV system and in the absence of another rule directly to the contrary) that the Agency could promulgate a reasonable rule that permitted claims to be submitted through the EVV system, which would then forward the claims to FMMIS."). In testimony at hearing, Mr. Black stated, "if things worked correctly, and we could resubmit claims properly ... I don't think anybody would have a problem, we wouldn't be here today."

Ultimate Facts Regarding Arbitrary and Capricious

75. Petitioner admits, through its responses to interrogatories and through Mr. Black's testimony, that the requirement that the Agency "mandate that all claims for ABA services be subject to verification of the claims data submitted" is a reasonable requirement, and, in fact, it is required by law that the Agency verify claims data submitted.

76. The Agency reviewed several options for the implementation of EVV in Florida, and, based on the needs of the Agency and the costs of implementing the system, the Agency determined that a model where the Agency contracts with an external vendor to operate the system would be the most efficient model for Florida. Ms. Vergeson testified:

> With the external contract, the external model that we chose to implement, that seemed – all things considered seemed to be the best approach for Florida. It's a one-stop shop. The system collects the information. The providers release the claims. The EVV system does the calculations that FMMIS did not have the capability of doing, verifies services, does sort of a prepayment review, and then transmits a file to the [FMMIS] for actual adjudication of the claims.

77. The external model offers several benefits to the Agency. As stated by Ms. Vergeson, "Having one vendor for the agency to manage greatly simplifies [the Agency's] ability to monitor that vendor, and require performance measures, and to make sure that that vendor is operating appropriately."

78. Ms. Vergeson identified some of those performance measures, including: (1) that no less than 95 percent of all claims are transmitted to FMMIS for adjudication and, then additionally, (2) that no more than five percent of those claims can be denied due to an issue with the vendor. For failing to hit these measures, there are monetary penalties. The Agency has imposed these penalties in the past "multiple times."

79. The Agency determined that this single point for submission would be the best approach to meet the needs of the Agency that is "solely responsible for managing the Medicaid program" and to "protect the integrity of the [Medicaid] program to the best extent possible."

80. Furthermore, as testified by Ms. Bennett, it is "[h]ands down" easier to prevent fraud from occurring than to recover the monies after they have been paid to providers.

81. Petitioner concedes that the model is "allowable and one of the recommended models by CMS." Petitioner acknowledges that the "External Method" is a method identified by CMS for implementing an EVV system.

Ultimate Facts Regarding Rulemaking Authority

82. The Agency has rulemaking authority to promulgate rules for the Medicaid program, pursuant to the grant of rulemaking authority present within section 409.919, that states the Agency "shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements." § 409.919, Fla. Stat.

83. The Agency followed all applicable rulemaking procedures pursuant to the Administrative Procedure Act, chapter 120, as confirmed by the testimony of Ms. Vergeson. Furthermore, Petitioner has not alleged any dispute as to whether the Agency followed all applicable rulemaking procedures. *See generally* Amended Petition.

Ultimate Facts Regarding NetSmart

84. Prior to the implementation of the Proposed Rule, the Agency implemented a Pilot Program in the Pilot Regions in Southeast Florida to determine whether EVV would be effective and to work through any issues with the implementation of a new system. The Agency contracted with NetSmart (formerly Tellus) for implementing the EVV system in the Pilot Regions prior to the implementation of the Proposed Rule.

85. The Agency worked with Netsmart to improve the operation of the EVV system in the Pilot Regions during the Pilot Program. The Agency has monitored the performance through the entirety of the contract. Ms. Vergeson testified that "there was a period of several months where as

more and more providers were using the system, issues would come to our attention, and we would work through our standard process. And then, in fact, we improved our internal processes, so that we can make sure that those issues get addressed, that fixes get put into place."

86. When preparing for the statewide expansion, the Agency included in its contract extension specific metrics to ensure "that any visits that are released by the providers in the Netsmart system are ultimately transmitted to FMMIS for claims adjudication. Every single week at least 95 percent of visits that are released must make it to FMMIS or there are financial penalties for the vendor." Additionally, when FMMIS adjudicates those claims "no more than five percent can get denied for an issue related to the vendor," or the vendor will be sanctioned by the Agency.

87. "For the past six weeks [from the time of the amendment to the Proposed Rule] since we've been monitoring based on that amendment, the claims submission rate has been 100 percent, and on a weekly basis the denial rate is approximately 1.8 percent on the average."

88. Mr. Black testified that there were significant problems very early in the implementation of EVV in the Pilot Regions, but that "we worked through a lot of problems, and some of the problems have – I mean, 100 percent gotten – you know, they have – they have gotten better."

89. Petitioner testified that the primary issues with the EVV system were "less to do with the gathering of the EVV data as much as they are to do with the transmission of the – the actual claim files to the FMMIS system."

90. There are no allegations that the Agency has not paid the claims at issue in this proceeding. Mr. Black stated during testimony that "they did reprocess and pay these claims, yes." His concern was with the speed of payment on occasion.

Ultimate Facts Regarding Petitioner's Purpose for Initiating the Rule Challenge

91. Petitioner has not identified any practice or methodology that is in the Proposed Rule that would preclude the prompt payment of claims or the reasonable functioning of the system for the purposes intended. The Proposed Rule does not provide that the intent of the Proposed Rule is to delay payments to providers, or that the system must function poorly and prevent providers from being paid.

92. As Ms. Bennett testified, while claims may be delayed because of technical issues or because of claims with errors in them, "EVV is not a process that slows claims down."

93. Petitioner is precluded, pursuant to the principle of res judicata, from asserting that the Agency's EVV system in the Pilot Regions is operating pursuant to an unadopted or unpromulgated rule. *Positive Behav. Support v. Ag. for Health Care Admin.*, Case No. 21-1789RU (Fla. DOAH July 23, 2021) (Final Order of Dismissal) (pending appeal).

94. Ms. Vergeson stated that she, on behalf of the Agency, was not aware of any other dispute regarding the proposed rule, other than the fact that providers will have to submit their services through EVV.

95. Petitioner's stated goal, through Mr. Black's testimony, with this litigation is not to prevent the Agency from using EVV, but rather, "[t]o make the claims that are generated after EVV data is … gathered correctly to be transmitted to the fiscal agent, FMMIS, so that they would be appropriately adjudicated, and either paid or denied based on the appropriateness of the claim."

96. Petitioner believes that EVV is a useful tool for detecting and deterring fraud and is reasonable.

97. Mr. Black admitted that the functioning of the EVV system in the Pilot Regions is the only reason for this rule challenge, stating "I think it would be fair to say, that if things – yeah, if things worked correctly, and we

could resubmit claims properly, if they were – needed to be resubmitted, yeah, I don't think anybody would have a problem, we wouldn't be here today."

98. The function of the EVV system in the Pilot Regions is an improper basis to support a rule challenge. To the extent that Petitioner has previously attempted to prosecute a rule challenge to contest the operation of the EVV system in the Pilot Regions, such challenge has already been litigated, dismissed with prejudice, and Petitioner is barred from re-litigating those issues pursuant to res judicata. *See id.*

99. Petitioner's attempt to rephrase its allegations to fit within the limits of a rule challenge is inappropriate, and an abuse of the administrative process, when Petitioner's true goal is to re-litigate allegations that have already been resolved, or that would be inappropriate in an administrative forum, such as adjudicating the denial of claims caused by an error in the functioning of the EVV system in the Pilot Regions.

Conclusions of Law

100. DOAH has jurisdiction over the subject matter and parties to this action, pursuant to sections 120.56, 120.569, and 120.57(1), Florida Statutes (2021).

101. Pursuant to section 120.56(2)(a), the following burdens of proof apply to a proposed rule challenge:

> The petitioner has the burden to prove by a preponderance of the evidence that the petitioner would be substantially affected by the proposed rule. The agency then has the burden to prove by a preponderance of the evidence that the proposed rule is not an invalid exercise of delegated legislative authority as to the objections raised.

102. Section 120.52(8) states that an "Invalid exercise of delegated legislative authority" means an:

[A]ction that goes beyond the powers, functions, and duties delegated by the Legislature. A proposed or existing rule is an invalid exercise of delegated legislative authority if any one of the following applies:

(a) The agency has materially failed to follow the applicable rulemaking procedures or requirements set forth in this chapter;

(b) The agency has exceeded its grant of rulemaking authority, citation to which is required by s. 120.54(3)(a)1.;

(c) The rule enlarges, modifies, or contravenes the specific provisions of law implemented, citation to which is required by s. 120.54(3)(a)1.;

(d) The rule is vague, fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency;

(e) The rule is arbitrary or capricious. A rule is arbitrary if it is not supported by logic or the necessary facts; a rule is capricious if it is adopted without thought or reason or is irrational; or

(f) The rule imposes regulatory costs on the regulated person, county, or city which could be reduced by the adoption of less costly alternatives that substantially accomplish the statutory objectives.

A grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only rules that implement or interpret the specific powers and duties granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary and capricious or is within the agency's class of powers and duties, nor shall an agency have the authority to implement

> statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than implementing or interpreting the specific powers and duties conferred by the enabling statute.

103. The "flush left" language is intended to restrict and narrow the scope of agency rulemaking. *See Sw. Fla. Water Mgmt. Dist. v. Save the Manatee Club, Inc.*, 773 So. 2d 594 (Fla. 1st DCA 2000); *Bd. of Trs. of the Internal Imp. Tr. Fund v. Day Cruise Ass'n, Inc.*, 794 So. 2d 696 (Fla. 1st DCA 2001). This language makes clear that the entire point of rulemaking is to "implement[ ] and interpret[ ] the specific powers and duties conferred" in a statute. *See* § 120.52(8), Fla. Stat.; *Day Cruise Ass'n*, 794 So. 2d at 700. An agency may not "improvis[e] in an area that can be said to fall only generally within some class of powers or duties the Legislature has conferred on the agency." *Id.*

104. Additionally, section 120.52(9) states that "Law implemented" is defined as "the language of the enabling statute being carried out or interpreted by an agency through rulemaking."

105. Section 120.56(1)(a) states that "any person substantially affected by a rule or proposed rule" may challenge such a provision. Section 120.56(1)(b)2. goes on to state that such a challenger must include "facts sufficient to show that [they] … would be substantially affected by the proposed rule" at issue.

106. It is undisputed that (a) PBS is a provider of Medicaid BA services and that (b) the challenged portion of the Proposed Rule will regulate providers of Medicaid BA services. The Agency has all but conceded this point. Although the Agency notes that the Medicaid program is voluntary in nature, PBS made clear that it has no intention to stop offering such services going forward. The Agency did not offer anything to the contrary.

Accordingly, it is clear that PBS will be regulated by the challenged portion of the Proposed Rule.

107. This regulation is "alone sufficient to establish that [PBS's] substantial interests will be affected" in this matter. *Coal. of Mental Health Pros. v. Dept. of Pro. Reg.*, 546 So. 2d 27, 28 (Fla. 1st DCA 1988). There is "no need for further factual elaboration" regarding exactly how such a petitioner will be affected once that basic showing is made. *Id.* "So long as it [is] made apparent that [a petitioner's] conduct" will be regulated by a proposed rule, its burden for standing has been met. *Id.*; *ABC Fine Wine & Spirits v. Target Corp.*, 321 So. 3d 896, 899 (Fla. 1st DCA 2021) ("Appellants are subject to the regulations set forth in the existing rule. This is sufficient to satisfy standing."); *see also Televisual Commc'ns, Inc. v. Dep't of Labor & Emp. Sec./Div. of Workers' Comp.*, 667 So. 2d 372, 374 (Fla. 1st DCA 1995); *Reiff v. Ne. Fla. State Hosp.*, 710 So. 2d 1030, 1032 (Fla. 1st DCA 1998); and *Ward v. Bd. of Trs.*, 651 So. 2d 1236, 1237 (Fla. 4th DCA 1995).

108. This line of case law regarding Florida's broad interpretation of standing in rule challenge proceedings is "consistent with the supreme court's contention that standing should be liberally applied" in such cases. *ABC*, 321 So. 3d at 899 (citing *NAACP v. Fla. Bd. of Regents*, 863 So. 2d 294, 300 (Fla. 2003)). Petitioner has clearly demonstrated its standing to challenge the Proposed Rule.

109. Petitioner asserts that the Proposed Rule is invalid because the rule violates section 120.52(8)(b), (d), and (e). Now that the issue of standing to proceed has been resolved in favor of Petitioner, it is necessary to discuss what objections to the Proposed Rule have been made by Petitioner in order to determine whether the Proposed Rule is an invalid exercise of the Agency's delegated legislative authority.

110. Petitioner, neither in its original or amended petition, nor during its presentation at the final hearing, objected to the Proposed Rule on the basis that the Proposed Rule "enlarges, modifies, or contravenes the specific

provisions of law implemented," and, therefore, pursuant to the express provision of section 120.56(2)(a), Petitioner has waived this potential objection to the Proposed Rule. The Agency thus does not have the burden here to prove that the Proposed Rule is an invalid exercise of delegated legislative authority on the basis that the Proposed Rule "enlarges, modifies, or contravenes the specific provisions of law implemented." §§ 120.52(8)(c) and 120.56(2)(a), Fla. Stat.

111. It is a well-settled principle that any claim that is not sufficiently pled is waived, even in the administrative context. *See TECO Energy, Inc. v. Williams*, 234 So. 3d 816, 823 (Fla. 1st DCA 2017) (finding that an affirmative defense must be timely and sufficiently plead by a claimant); *See also McFarlane v. Miami-Dade Transit Auth.*, 215 So. 3d 658, 660 (Fla. 1st DCA 2017) (finding no amendment or supplemental pleading may be used to raise a new claim or defense that was not raised in the initial pretrial stipulation in Workers' Compensation cases). Even if Petitioner had failed to timely and sufficiently plead its specific objections, which it did not, Netsmart's performance cannot be used to demonstrate that the proposed rule "enlarges, modifies, or contravenes the specific provisions of law implemented" or is beyond the Agency's rulemaking authority, because its actions were not performed pursuant to the provisions of the Proposed Rule. *See Hospice of the Fla. Suncoast, Inc. v. Ag. for Health Care Admin.*, Case No. 15-3656RX, FO at ¶ 54 (Fla. DOAH Sept. 28, 2016), *aff'd per curiam*, 203 So. 3d 159 (Fla. 1st DCA 2016) (finding that a "rule challenge pursuant to section 120.56 is directed to the facial validity of the challenged rule, and not to its validity as interpreted or applied in specific factual scenarios"); *See also Fairfield Cmties. v. Fla. Land & Water Adj. Comm'n*, 522 So. 2d 1012, 1014 (Fla. 1st DCA 1988) (in deciding the facial validity of rules promulgated by an administrative agency, only the statutory basis for the rules need be examined to determine whether the agency has exceeded its authority).

112. Petitioner's ultimate assertion rests not on eliciting proof that the requirements of the proposed rule are beyond the Agency's delegated legislative authority, but rather, that the Agency's specific choice of vendor is an invalid delegation of legislative authority because the vendor's performance is inadequate in Petitioner's estimation.

113. To even reach the question of whether the Agency's choice of vendor is an invalid delegation of legislative authority, the undersigned must first reach the conclusion that the Agency has the legislative authority to choose a vendor. If that conclusion is reached, then the Agency has a lawful Proposed Rule. Thus, because the actions of Netsmart have no bearing on whether the Agency has exceeded its legislative authority, they are immaterial and irrelevant to this hearing.

114. Moreover, a major point made by Mr. Black, Ms. Lexima, and Ms. Donahue in their testimony at hearing was that the delays in reimbursement of their claims in some way leads to a finding by the undersigned that the Proposed Rule is an invalid exercise of delegated legislative authority. As Ms. Bennett, correctly, albeit bluntly, testified, it is not the Agency's concern that providers have to wait as much as two weeks (or longer in more isolated instances) to be reimbursed and that waiting could force them to borrow money or even mortgage assets to cover payroll and expenses. The Agency is concerned first and foremost with paying valid, reimbursable claims in a timely manner. The fact that payments may have previously been made within 48 hours of submission, and now may take a week or two, does not render the rule invalid. There may be some form of action that could be brought in state court to deal with delayed payments, but a rule challenge under chapter 120 is not the method for dealing with a vendor the providers deem to be inadequate.

The Proposed Rule Is Not Vague

115. A rule is impermissibly vague "if it forbids or requires the performance of an act in terms that are so vague that persons of common intelligence must guess at its meaning and differ as to its application. Generally, where words or phrases are not defined, they must be given their common and ordinary meaning. '[T]he plain and ordinary meaning of [a] word can be ascertained by reference to a dictionary.'" *Dep't of Fin. Servs. v. Peter R. Brown Constr., Inc.*, 108 So. 3d 723, 728 (Fla. 1st DCA 2013) (internal citations omitted). The Proposed Rule is not vague. Every individual who testified stated that, while EVV may be more burdensome on providers than Medicaid blindly paying providers immediately, the implementation of EVV is still a beneficial policy for the Agency to pursue.

116. Each of Petitioner's witnesses clearly understood the effect of the Proposed Rule. Ms. Lexima, when asked what part of the rule was vague or that she did not understand stated, "No, I understand the rule. I understand it. I understand this document, this notice of change document. I understand what's outlined here."

117. Petitioner has attempted to stretch its argument that the Proposed Rule is vague by arguing that, while it is now clear that claims must be submitted to the EVV system, "for resubmission it's not clear at all because under the handbook the only means of electronic submission considered is through FMMIS." This is true, but is an inaccurate reading of the Proposed Rule in conjunction with the Reimbursement Handbook. Under the provisions of the Proposed Rule, all claims will be adjudicated by FMMIS. The Proposed Rule does nothing to change this fact, and claims will all be submitted to FMMIS, even if they must first be submitted through the EVV system. Moreover, Petitioner's attempt to separate submission and resubmission into two separate processes is splitting definitional hairs. Even when Petitioner's counsel referred to the issue, he stated, "the only means of electronic

submission considered is through FMMIS," which implicitly agrees with the common understanding that submission and resubmission are the same.

118. The Reimbursement Handbook does not grant providers of a service an affirmative, legal right to submit claims to the Medicaid program. Only those providers who have voluntarily executed a Provider Agreement, that are in good standing with the Agency, and have, therefore, become "Medicaid providers," may be paid for services rendered to Medicaid recipients. § 409.907, Fla. Stat. Further, Petitioner has no expectation of continued participation in Medicaid. § 409.907(13), Fla. Stat.; *Diaz*, 65 So. 3d at 82-83 (finding that despite being longtime providers to Florida Medicaid and expecting to continue participating, such expectation is not appropriate based on the statutory authority and case law).

119. The Reimbursement Handbook does not mention "FMMIS" when describing the process of "How to Resubmit a Denied Claim." In fact, the only statement on where to send a resubmitted claim refers to paper claims, and states, "Do you have the correct P.O. Box Number and corresponding nine-digit zip code for mailing the resubmitted claim? Resubmitted claims should be sent to the same P.O. Box as the original claim." Based on this excerpt, it is clear that the Reimbursement Handbook views both submission and resubmission as the same process, and claims should be resubmitted to the same location as the original submission. Further, under the section "Where to Send Claim Forms," the Reimbursement Handbook contemplates that both the original CMS-1500 and the Resubmitted CMS-1500 claims are to be sent to the same location.

120. It is also factually inaccurate to state that providers may not use their own billing agent to submit claims to the EVV system, because the Proposed Rule does not prevent any provider from using a billing agent. Ms. Lexima, testifying for Petitioner, confirmed this when she testified that she used a billing agent to bill the EVV system in the Pilot Regions. Further, the wording of the Proposed Rule makes it clear that all submissions,

including resubmissions, are to be submitted through the Agency's EVV system for BA service claims.

121. Case law does not require the Agency to address how the rule will be applied in a particular set of facts, so long as the meaning of the language is clear on its face. *See Env't Tr. v. State, Dep't of Env't Prot.*, 714 So. 2d 493, 498 (Fla. 1st DCA 1998) (stating, "An agency statement explaining how an existing rule of general applicability will be applied in a particular set of facts is not itself a rule. If that were true, the agency would be forced to adopt a rule for every possible variation on a theme, and private entities could continuously attack the government for its failure to have a rule that precisely addresses the facts at issue. Instead, these matters are left for the adjudication process under section 120.57, Florida Statutes.").

122. As ALJ Elizabeth W. McArthur informed Petitioner in her Final Order dismissing its unadopted rule challenge, with prejudice:

> Equally untenable would be to allow private entities to utilize the unadopted rule challenge process, with its attendant provision for attorney's fees, to attack government for technical errors arising during a transition to a new electronic system developed and operated by a vendor. No doubt such errors are frustrating to Petitioner and interfere with the smooth operations of its business. But system errors are part of the promulgated claim process, subject to a promulgated resolution process, and should be dealt with accordingly, by seeking the allowable relief as to the improperly denied claims.

Positive Behav. Support, Case No. 21-1789RU, FOD at ¶ 66.

123. Regardless, the Notice of Change clarifies any ambiguity that may have existed with regard to optional services, such as the electronic submission of claims directly to FMMIS, as implied by the Reimbursement Handbook, by stating that "Neither a provider who furnishes home health or behavior analysis services, nor a billing agent of that provider, may submit

claims directly to the Florida Medicaid fiscal agent irrespective of any other provision including, but not limited to, Rule 59G-4.001, F.A.C."

124. The Proposed Rule does not make any further exceptions to the provisions of the Reimbursement Handbook, or to any other provision of law, beyond the expressed clarification found in the Notice of Change (J. Ex. 2 at subsection (3)(b)3.) to address and remedy any ambiguity in how the regulatory framework will function. A "person of common intelligence" would not consider the language vague about whether the Proposed Rule requires BA services to be submitted to the EVV system before being processed by the Agency's fiscal agent.

<u>The Agency's Interpretation of EVV Is Neither Arbitrary nor Capricious under Section 120.52(8)(e), Florida Statutes</u>

125. "A rule is arbitrary if it is not supported by logic or the necessary facts and capricious if it is adopted without thought or reason or is irrational." *Dep't of Elder Aff. v. Fla. Senior Living Ass'n, Inc.*, 295 So. 3d 904, 912 (Fla. 1st DCA 2020) (quoting *Fla. E. Coast Indus. Inc. v. Dep't of Cmty. Aff.*, 677 So. 2d 357, 362 (Fla. 1st DCA 1996), and § 120.52, Fla. Stat.) A proposed rule is "arbitrary if it is not supported by logic or the necessary facts." The logic of this rule was demonstrated repeatedly through testimony at hearing. Petitioner itself, along with Petitioner's witnesses, support the use of an EVV system to combat fraud. The fact that there was, and still is, rampant fraud in the BA program was also well-established throughout the hearing and reflected in the testimony of Petitioner and Petitioner's witnesses. Petitioner itself has had employees abusing the exact same service type at issue in this hearing, fraud which was identified through Petitioner's own use of an EVV system. A proposed rule is "capricious if it is adopted without thought or reason or is irrational." The Agency witness, Ms. Vergeson, testified repeatedly that the Agency had put significant thought into the method for employing EVV in this state. The reason for it—

the rampant fraud and abuse occurring by BA providers—is also well documented.

126. Petitioner's arguments that the rule is arbitrary and capricious because of any action by NetSmart is immaterial to the determination of whether the Agency's implementation of an EVV requirement is arbitrary or capricious. The actions or practice of a third party have no bearing on whether the Agency has the legislative authority to promulgate the policy at issue in this proceeding. Further, to the extent the parties wish to challenge a reimbursement methodology or manner of reimbursement to providers, this is not the appropriate forum. *See* Cathy A. Sellers, *Overview of the Administrative Procedure Act*, pp. 2-39, Florida Administrative Practice (13th Edition 2021) (stating "[a] challenge to a proposed or existing rule under F.S. 120.56 is directed only to the invalidity of the rule itself and does not address the legality of the manner in which the rule is being applied or enforced." citing *Beverly Health & Rehab. Servs., Inc. v. Ag. for Health Care Admin.*, 708 So. 2d 616 (Fla. 1st DCA 1998)).

127. It is undisputed that the Agency has worked with its vendor to drastically improve the system since the implementation of the Pilot Program, and that providers have been able to adapt. The Agency's specific metrics moving forward address Petitioner's primary concerns with the EVV system failing to properly transmit claims to FMMIS for processing. Based upon the ample evidence of fraud, the Agency's implementation of EVV is a reasonable response to the fraud and abuse observed and prosecuted within the BA provider type of service.

128. While Petitioner may argue it is unreasonable for the Agency to employ an EVV system with a history of problems, it is not appropriate to weigh the issues with the initial implementation of the system greater than the system's current status, or to let every BA service provider employ its own EVV system, which would logically lead to even further issues. Petitioner has conceded that glitches and errors are commonplace in new

systems. Furthermore, Petitioner agreed that "EVV in and of itself is reasonable." In short, Petitioner has not proven that the Proposed Rule was adopted without thought or reason, or on a whim.

The Agency Has Not Exceeded Its Grant of Rulemaking Authority under Section 120.52(8)(b), Florida Statutes

129. Rulemaking authority is defined as "statutory language that explicitly authorizes or requires an agency to adopt, develop, establish, or otherwise create any statement coming within the definition of the term 'rule.' As a result, any agency action that goes beyond the powers, functions, and duties delegated by the Legislature constitutes an invalid exercise of delegated legislative authority." *Fla. Senior Living Ass'n, Inc.*, 295 So. 3d at 909. When determining whether a rule exceeds its grant of legislative authority, the First District Court of Appeal has stated that the tribunal should focus on whether "the statute contains a specific grant of legislative authority for the rule, as opposed to whether the grant of authority is specific enough. Either the enabling statute authorizes the rule at issue or it does not." *Id.* at 910 (quoting *Sw. Fla. Water Mgmt. Dist. v. Save the Manatee Club, Inc.*, 773 So. 2d 594, 598 (Fla. 1st DCA 2000)).

130. The Agency has significant and broad rulemaking authority to promulgate Medicaid rules regarding payment, to review claims for fraud and abuse, and to use technology, such as the FMMIS system or the EVV system at issue in this proceeding, before adjudicating whether to pay or deny a claim. *See generally*, §§ 409.901-409.920, Fla. Stat. (Section 409.919 states that "[t]he agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements.").

131. Section 120.52(8) further states that "[a] grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only

rules that implement or interpret the specific powers and duties granted by the enabling statute."

132. Despite all the noise made at hearing about how the EVV system is not working properly and denying providers timely payment of their claims, both of which were refuted by the facts that, ultimately and not unreasonably in terms of length of time, claims have been paid and the EVV system for submission and reimbursement of claims has improved markedly over time, the Proposed Rule is clearly within the general grant of rulemaking authority in section 409.919. While Petitioner may assert that implementing this requirement is outside its rulemaking authority, Petitioner's arguments do not address section 409.919, but rather, the laws implemented by the Proposed Rule, i.e., sections 409.906, 409.913, and 409.9132. *See* Notice of Change, Joint Exhibit 2, which states, "Rulemaking Authority 409.919, ~~409.961~~ FS. Law Implemented 409.905, 409.906, 409.913, 409.9132, ~~409.973~~ FS."

133. However, as set forth previously, the petition does not assert, and Petitioner has made no claim, that the Proposed Rule violates section 120.52(8)(c), i.e., that the Proposed Rule "enlarges, modifies, or contravenes the specific provisions of law implemented," and its failure to make such a claim waives its right to assert that the Proposed Rule is invalid because the Proposed Rule exceeds the boundaries of the specific law implemented. § 120.56, Fla. Stat.

134. Petitioner has conceded that the Agency has the authority to require EVV in BA on multiple instances and in various contexts throughout the proceeding. Despite these concessions and the Agency's broad rulemaking authority, Petitioner argues that because EVV is authorized in home health by section 409.9132, and the statute is silent on BA services, this silence indicates that the Agency is forbidden from using EVV to review BA claims. However, this claim does not address the Agency's rulemaking authority, but rather, whether the Proposed Rule exceeds the scope of the law implemented.

135. In the rule challenge here, section 409.913 is the clearest expression of legislative intent for the integrity of the Medicaid program and provides the Agency broad authority to contract with private entities to prevent and deter fraud, where doing so is advantageous and cost-effective to the state to safeguard the Medicaid program. § 409.913, Fla. Stat.

136. Section 409.913 states that:

> The agency 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, … .
>
> * * *
>
> (2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.
>
> (3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year.
>
> * * *
>
> (11) 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.

137. The record is filled with testimony from Petitioner's witnesses who have either used an EVV system to detect and deter fraud or stated their belief that the use of EVV will unquestionably safeguard the Medicaid program and is desirable to all parties. A finding that the Agency may not use an efficient, effective, and reasonable system to prevent and deter fraud simply because that system is authorized to be used by Medicaid for another provider type would defeat the "natural and obvious sense" of the Medicaid statute's provisions to prevent and deter fraud of the Medicaid program and to ensure that they occur to the minimum extent possible.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that the Amended Petition Challenging Subsection (3)(b)3. of Proposed Florida Administrative Code Rule 59G-4.132 is hereby DISMISSED.

DONE AND ORDERED this 18th day of November, 2021, in Tallahassee, Leon County, Florida.

ROBERT S. COHEN
Administrative Law Judge
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of November, 2021.

COPIES FURNISHED:

William D. Hall, III, Esquire
Dean Mead and Dunbar
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

Jordane Wong, Esquire
Dean Mead and Dunbar
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

Bradley S. Butler, Jr., Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Timothy P. Sparks, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Shena L. Grantham, Esquire
Agency for Health Care Administration
Building 3, Room 3407B
2727 Mahan Drive
Tallahassee, Florida 32308

Simone Marstiller, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida 32308

Margaret Swain
Florida Administrative Code
and Register
Department of State
R. A. Gray Building
500 South Bronough Street
Tallahassee, Florida 32399-0250

Daniel R. Russell, Esquire
Dean Mead and Dunbar
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

John L. Wharton, Esquire
Dean Mead and Dunbar
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

Thomas M. Hoeler, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

William H. Roberts, Acting General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Anya Owens, Program Administrator
Florida Administrative Code
and Register
Department of State
R. A. Gray Building
500 South Bronough Street
Tallahassee, Florida 32399-0250

Ken Plante, Coordinator
Joint Administrative Procedures Committee
Room 680, Pepper Building
111 West Madison Street
Tallahassee, Florida 32399-1400

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the district court of appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.