STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GLADES HEALTH PLAN, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	CASE NO. 95-4140RU
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
_____	)	

FINAL ORDER

Pursuant to notice, a hearing was held in the above-styled case before Richard Hixson, a Hearing Officer assigned by the Division of Administrative Hearings, on September 15, 1995, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Theodore E. Mack, Esquire
131 North Gadsden Street
Tallahassee, Florida 32301

For Respondent: Heidi E. Garwood, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32309

STATEMENT OF THE ISSUES

The issues for determination in this case are whether the following agency statements violate the provisions of Section 120.535, Florida Statutes:

1) No pending Medicaid Prepaid Health plan contract applications will be reviewed approved or denied.
2) Medicaid Prepaid Health Plan contracts are not licenses as that term is defined in subsection (9) of Section 120.52, Florida Statutes.

PRELIMINARY STATEMENT

On August 22, 1995, Petitioner, GLADES HEALTH PLAN, INC., filed a Petition with the Division of Administrative Hearings alleging that certain statements and policies of Respondent, AGENCY FOR HEALTH CARE ADMINISTRATION, violated the provisions of Section 120.535, Florida Statutes, because such statements constituted rules under Section 120.52(16), Florida Statutes, and should accordingly have been promulgated as rules pursuant to Section 120.54, Florida

Statutes. The Petition specifically challenged the following statements alleged to have been made by the agency:

> 1. No pending Medicaid prepaid health plan contract applications will be reviewed approved or denied.
> 2. Commercial HMO licensure is a condition precedent to obtaining a Medicaid prepaid health plan contract.
> 3. Medicaid prepaid health plan contracts are not licenses as that term is defined in subsection (9) of Section 120.52, Florida Statutes.

At hearing on September 15, 1995, Petitioner withdrew its challenge to the second alleged agency statement, set forth above, that commercial HMO licensure is a condition precedent to obtaining a Medicaid Prepaid Health Plan contract. The hearing proceeded on the remaining issues.

Petitioner presented the testimony of James M. Barclay, vice-president of GLADES HEALTH PLAN, INC., and two exhibits which were received into evidence. Respondent presented the testimony of Tom Arnold, Chief of the Bureau of Managed Care for the AGENCY FOR HEALTH CARE ADMINISTRATION, and one exhibit which was received into evidence.

A transcript of the hearing held in this case was filed on September 19, 1995.

On October 16, 1995, Petitioner and Respondent each filed a proposed final order. Rulings on the proposed findings of fact submitted by the parties are set forth in the Appendix attached hereto.

FINDINGS OF FACT

1. Petitioner GLADES HEALTH PLAN, INC., (GLADES) is a for-profit corporation with offices in Belle Glade, Florida. GLADES was formed for the purpose of applying for and obtaining a contract with the State of Florida for a Medicaid Prepaid Health Plan.

2. Respondent, AGENCY FOR HEALTH CARE ADMINISTRATION, (AHCA), is the agency of the State of Florida statutorily responsible for the administration of the Florida Medicaid prepaid health plan program.

3. On October 5, 1994, GLADES filed a Medicaid prepaid health plan contract application with AHCA.

4. In December of 1994, a series of newspaper articles were published which raised concerns regarding the quality of health care and service provided by Medicaid prepaid health plans in Florida.

5. In response to these concerns, AHCA, beginning in the latter part of December of 1994, implemented a number of administrative changes, and also undertook a comprehensive review to assess the quality of health care and service provided by existing Medicaid prepaid health plans.

6. In order to accomplish this comprehensive review, AHCA redirected all of the agency's managed care staff to conduct a survey of the assessment of the quality of health care and services provided by the existing Medicaid prepaid health plans.

7. Because AHCA's managed care staff was redirected to conduct this comprehensive review of the existing Medicaid prepaid health plans, there were insufficient staff available to review Medicaid prepaid health plan contract applications. AHCA was also concerned with contracting with additional health plans until the assessment of the existing plans was completed. AHCA accordingly placed a temporary moratorium on the consideration of applications for Medicaid prepaid health plan contracts until the completion of the comprehensive review. The purpose of the agency's comprehensive review of existing health plans and imposition of a temporary moratorium on pending contract applications for new health plans was to assess the quality of care and service of the existing Florida Medicaid prepaid health plan program, and to develop in-house agency policies to address problems identified by agency staff conducting the comprehensive review.

8. On December 30, 1994, James M. Barclay, vice-president of GLADES, received a letter from AHCA relating to another organization with which he is affiliated, Heartland Healthcare, Inc., which like GLADES, had filed a Medicaid prepaid health plan contract application that was pending with AHCA.

9. The December 30, 1994 letter from AHCA to Barclay recited AHCA's concern with the quality of health care and service provided by existing Medicaid prepaid health plans. The letter further stated that due to the implementation of administrative changes, and the need for agency staff to be committed to the comprehensive review of existing Medicaid prepaid health plans, AHCA had imposed a moratorium on the consideration of Medicaid Prepaid Health Plan contract applications to last approximately sixty to ninety days.

10. GLADES did not receive a letter, or other communication from AHCA notifying GLADES of AHCA's imposition of a temporary moratorium on the consideration of its Medicaid prepaid health plan contract application, and no action was taken by AHCA with regard to the GLADES' contract application during this period.

11. Upon completion of the agency's comprehensive review of existing Medicaid prepaid health plans, AHCA, in the spring of 1995, discontinued the moratorium on consideration of Medicaid prepaid health plan contract applications.

12. In processing Medicaid prepaid health plan contract applications subsequent to the discontinuation of the moratorium, AHCA determined not to contract with any prepaid health plan unless the plan was a public entity, or commercially #licensed under the provisions of Chapter 641, Florida Statutes. The basis for AHCA's decision in this regard was that the agency's comprehensive review of Medicaid prepaid health plans indicated that the existing commercially licensed Medicaid prepaid health plans provided a better quality of care to Medicaid recipients than the health plans that were not commerically licensed.

13. On September 13, 1995, AHCA filed with the Department of State, Bureau of Administrative Code, proposed rules amending Rule 59G-8.100, Florida Administrative Code. The proposed rule amendments set out criteria for AHCA's consideration of Medicaid prepaid health plan contract applications. The criteria include commercial licensure under Chapter 641, Florida Statutes,

managed care accreditation, prior health care experience, and need for managed care services. Under the proposed rule amendments, failure to meet such criteria, including commercial licensure, is grounds for denial of a Medicaid prepaid health plan contract application.

14. AHCA has not promulgated or instituted proceedings to promulgate rules regarding the temporary moratorum imposed in this case.

15. GLADES is not commercially licensed under the provisions of Chapter 641, Florida Statutes.

16. Subsequent to the discontinuation of the moratorium, AHCA has taken no action with regard to GLADES' Medicaid prepaid health plan contract application.

17. Because GLADES is not commercially licensed, AHCA presently considers the GLADES' Medicaid prepaid health plan contract application inactive.

18. AHCA has not written, published or otherwise made a formal statement of agency policy to the effect that Medicaid prepaid health plan contracts are not licenses as that term is defined in Section 120.52(9), Florida Statutes.

19. AHCA has not promulgated or instituted proceedings to promulgate rules to the effect that Medicaid prepaid health plan contracts are not licenses.

CONCLUSIONS OF LAW

20. The Division of Administrative Hearings has jurisdiction of the parties to and the subject matter of this proceeding. Section 120.535, Florida Statutes.

21. The initial burden of proof in this proceeding is on the Petitioner to prove the allegations of the Petition and establish by a preponderance of the evidence that the agency statements violate the provisions of Section 120.535(1), Florida Statutes. Section 120.535(2)(b), Florida Statutes. See Agrico Chemical Co. v. State Department of Environmental Regulation, 365 So. 2d 759, 762 (Fla. 1st DCA 1978); Dravo Basic Material Co., Inc. v. State Department of Transportation, 602 So. 2d 632 (Fla. 2d DCA 1992).

22. Section 120.535(1), Florida Statutes provides:

> (1) Rulemaking is not a matter of agency discretion. Each agency statement defined as a rule under s. 120.52(16) shall be adopted by the rulemaking procedure provided by s. 120.54 as soon as feasible and practicable. Rulemaking shall be presumed feasible and practicable to the extent provided by this subsection unless one of the factors provided by this subsection is applicable.
>
> (a) Rulemaking shall be presumed feasible unless the agency proves that:
>
> 1. The agency has not had sufficient time to acquire the knowledge and experience reasonably necessary to address a statement by rulemaking; or
>
> 2. Related matters are not sufficiently resolved to enable the agency to address a

statement by rulemaking; or

3. The agency is currently using the rulemaking procedure expeditiously and in good faith to adopt rules which address the statement.

(b) Rulemaking shall be presumed practicable to the extent necessary to provide fair notice to affected persons of relevant agency procedures and applicable principles, criteria, or standards for agency decisions unless the agency proves that:

1. Detail or precision in the establishment or principles, criteria, or standards for agency decisions is not reasonable under the circumstances; or

2. The particular questions addressed are of such a narrow scope that more specific resolution of the matter is impractical outside of an adjudication to determine the substantial interests of a party based on individual circumstances.

23. Section 120.52(16), Florida Statutes, in pertinent part, defines "rule" as follows:

(16) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the organization, procedure, or practice requirements of an agency and includes any form which imposes any requirement or solicits any information not specifically required by statute or by an existing rule. The term also includes the amendment or repeal of a rule.

24. To determine whether AHCA's imposition of a temporary moratorium on the consideration of Medicaid prepaid health plan contract applications is a rule depends in part on the effect of the moratorium. State Board of Trustees of the Internal Improvement Trust Fund v. Lost Tree Village Corporation, 600 So. 2d 1240, 1244 (Fla. 1st DCA 1992); Balsam v. Department of Health and Rehabilitative Services, 452 So. 2d 976 Fla. 1st DCA 1977).

25. In this case, the initial effect of the temporary moratorium delayed AHCA's consideration of the GLADES' contract application until completion of the comprehensive review of existing health plans. Subsequent to the completion of the agency's comprehensive review, and as a result of the information obtained by the agency from the comprehensive review, AHCA determined that commercial licensure should be a precedent to the consideration of Medicaid prepaid health plan contract applications. This change in the agency's policy as reflected by the proposed amendments to Rule 59G-8.100, Florida Administrative Code, has had the further effect of placing the GLADES' Medicaid prepaid health plan contract application on inactive status with the agency.

26. In Lost Tree Village, supra, the Court held that the Board of Trustees of the Internal Improvement Trust Fund's imposition of a temporary moratorium on the consideration of applications to conduct activities on state owned submerged lands was not a rule as defined in Section 120.52(16), Florida Statutes. In its prior decision in Balsam, supra, the Court had, however, held that a temporary moratorium imposed by the Department of Health and Rehabilitative Services on

the consideration of certificate of need applications met the definition of a rule. The Court in Lost Tree Village, distinguished the prior decision in Balsam "...because a statute and a rule expressly required HRS to review applications on a timely basis, whereas here the Board is not subject to such a time requirement and, in fact, is not required to even accept applications." Supra, 600 So. 2d at 1244.

27. In this case, Sections 409.912(2)(3) and (4), Florida Statutes provide:

> (2) The department may contract with health maintenance organizations certified pursuant to part 1 of chapter 641 for the provision of services to recipients.
> (3) The department may contract with county public health units and other entities authorized by chapter 154 to provide health care services on a prepaid or fixed-sum basis to recipients, which entities may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services are exempt from the provision of part 1 of chapter 641.
> (4) The department may contract with any public or private entity on a prepaid or fixed-sum basis for the provision of health care services to recipients.
> (a) Any entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:
> 1. Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;
> 2. Ensures that services meet the standards set by the department for quality, appropriateness, and timeliness;
> 3. Makes provisions satisfactory to the department for insolvency protection and ensures that neither enrolled Medicaid recipients nor the department will be liable for the debts of the entity;
> 4. Submits to the department, if a private entity, a financial plan that the department finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses of $200,000 whichever is greater;
> 5. Furnishes evidence satisfactory to the department of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;
> 6. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the department; and

7. Provides organizational, operational, financial, and other information required by the department.

28. As in Lost Tree Village, there is no express statutory requirement for AHCA to review Medicaid prepaid health plan contract applications on a timely basis. Additionally, as in Lost Tree Village the statutes does not specifically require the agency to even accept such contract applications.

29. Rules 59G-8.100(4), and (5), Florida Administrative Code set forth the contract application procedure and approval process, and provide:

> (4) Application for a Prepaid Plan. Before an eligible contractor may enter into a contract with the agency to provide services under a prepaid plan, it shall submit an application. The application shall be in a form which the agency has determined contains sufficient information to allow the agency to assess the applicant's legal, financial and organizational capability to provide services under a prepaid plan. The application shall contain at least the following information.
> (a) A list of the names, addresses and official capacities of the officers and directors with the applicant.
> (b) A list of the names, addresses and official capacities of the managing employee and other persons who are to be responsible for the conduct of the affairs of the prepaid plan.
> (c) A description of the prepaid plan and its organizational relationship to the applicant, its operations, and the manner in which services will be regularly available.
> (d) Proposed procedures and policies relating to Medicaid service delivery and administration, including but not limited to:
> 1. Marketing
> 2. Enrollment and disenrollment
> 3. Quality assurance
> 4. Grievances
> 5. Provision for insolvency protection
> 6. Insurance and bonding
> 7. Subcontracts
> (e) The nature, extent and disposition of civil or criminal actions against the applicant and any predecessor organization and any person with ownership or controlling interest of the applicant or who is an agent managing employee of the applicant.
> (f) The name and address of each person with a 5 percent or more ownership or control interest in the applicant or in any subcontractor or supplier in which the applicant has direct or indirect ownership of 5 percent of more. Identify if any of the persons named are related to another named person as spouse, parent, child, or sibling.
> (g) Financial information sufficient to determine

> the financial soundness of the applicant and the applicant's ability to insure the risk association with operating a prepaid health plan. An HMO with a current operating certificate may submit the latest annual and quarterly reports required under applicable provisions of part II of chapter 641, Florida Statutes.
>
> (h) A description of the geographic area or areas to be served by the prepaid health plan.
>
> (5) Approval process.
>
> (a) Approval of the application shall be based on the criteria established in federal regulations and state statutes and rules.
>
> * * *
>
> (c) Agency approval of the final procedures, policies, materials and forms relating to the delivery and administration of Medicaid services, including but not limited to those listed in subsection 4(d), is required to plan implementation.

30. As in Lost Tree Village, supra, there is no express requirement contained in Rules 59G-8100(4) and(5), Florida Administrative Code, that AHCA must review Medicaid prepaid health plan contract applications on a timely basis.

31. Under these circumstances, absent a showing that AHCA acted in an arbitrary or capricious manner which is not demonstrated by the evidence in this case, AHCA's statement regarding the imposition of a temporary moratorium on the consideration of Medicaid prepaid health plan contract applications does not constitute a rule as that term is defined in Section 120.52(16), Florida Statutes. Moreover, as the Court noted in Lost Tree Village, the purpose of the temporary moratorium in this case was to review the existing agency program and to develop in-house agency policies to address problems identified with the program.

32. Furthermore, even if AHCA's statement regarding the temporary moratorium imposed in this case were to be considered a rule, the statement is no longer applied. Under these circumstances, to require the agency to institute rulemaking procedures regarding the discontinued temporary moratorium would have no actual effect at this time and the allegations of the Petition in this respect are moot. Montgomery v. Department of Health and Rehabilitative Services, 468 So. 2d 1014, 1016 (Fla. 1st DCA 1985).

33. In this case, AHCA has discontinued the moratorium on consideration of Medicaid prepaid health plan contract applications, and has instituted rulemaking procedures which specify the agency's clear statement of policy regarding the requirements for consideration of a Medicaid prepaid health plan contract. The preponderance of the evidence in this case does not support a finding here that AHCA's statement imposing a temporary moratorium violated the provisions of Section 120.535(1), Florida Statutes.

34. The preponderance of the evidence also fails to establish that AHCA has written, published, or otherwise made a formal statement of agency policy to the effect that Medicaid prepaid health plan contracts are not licenses as that term is defined in Section 120.52(9), Florida Statutes.

FINAL ORDER

Based on the foregoing findings of fact and conclusions of law, it is

ORDERED that the Petition for Determination that Agency Statements Violate Section 120.535, Florida Statutes be DISMISSED.

DONE and ENTERED this 30th day of October, 1995, in Tallahassee, Leon County, Florida.

RICHARD HIXSON
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of October, 1995.

APPENDIX

As to Petitioner's proposed findings:

1.-8. Accepted and incorporated.
9.-12. Accepted, but subordinate and unnecessary.
13.-15. Accepted and incorporated.

As to Respondent's proposed findings:

1.-12. Accepted and incorporated.

COPIES FURNISHED:

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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 one copy of a Notice of Appeal with the Agency Clerk of the Division of Administrative Hearings, and a second copy accompanied by filing fees prescribed by law with the District Court of Appeal, First District, or with the District Court of Appeal in the appellate district where the party resides. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.