STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

SUNRISE COMMUNITY, INC., Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 98-3946RP

FINAL ORDER

Pursuant to notice, a Section 120.57(1) hearing was conducted in this case on October 21 and 22, 1998, in Tallahassee, Florida, before Stuart M. Lerner, a duly designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Steven M. Weinger, Esquire
Helena Tetzeli, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent's proposed amendment of Rule 59G-6.040, Florida Administrative Code, and Respondent's proposed new Rule

59G-6.045, Florida Administrative Code, would be invalid exercises of delegated legislative authority, within the meaning of Chapter 120, Florida Statutes, for the reasons asserted by Petitioner.

PRELIMINARY STATEMENT

On September 9, 1998, Petitioner filed a petition with the Division of Administrative Hearings (Division) challenging Respondent's proposed amendment of Rule 59G-6.040, Florida Administrative Code, and the proposed adoption by Respondent of a new rule, Rule 59G-6.045, Florida Administrative Code, entitled "Payment Methodology for Services in Facilities Not Publicly Owned and Publicly Operated (Facilities Formerly Known as ICF/DD Facilities)." In its petition, Petitioner identified itself as "a provider of ICF/MR services both in publicly owned and not publicly owned facilities."

By order issued September 11, 1998, the Division's Chief Judge assigned the case to the undersigned Administrative Law Judge, who, on September 15, 1998, issued a Notice of Hearing scheduling the final hearing in this case for October 6 and 7, 1998. On September 18, 1998, Petitioner filed an unopposed motion requesting that the final hearing be continued. Finding that Petitioner had shown good cause for a continuance, the undersigned, on September 24, 1998, issued an Order granting Petitioner's motion. The final hearing was subsequently rescheduled for October 21 and 22, 1998.

On September 25, 1998, Respondent filed a Motion to Dismiss requesting that the undersigned issue an order "dismissing Petitioner's challenge to Proposed Rule 59G-6.040 for lack of substantial affect." In its motion, Respondent argued that "Petitioner is not 'substantially affected' by the proposed amendment to Rule 59G-6.040 because the rule only applies to reimbursement for public facilities and public entities and not to a private entity [like Petitioner] which operates a public facility." On September 29, 1998, the undersigned issued an Order denying Respondent's Motion to Dismiss, in which he gave the following explanation for his ruling:

> A challenge to a proposed rule amendment may be initiated only by those who would be "substantially affected" if the proposed rule amendment were adopted. Section 120.56(2), Florida Statutes. To establish its "substantially affected" status, a would-be challenger must show that, as a consequence of the adoption of the proposed rule amendment, it would suffer a real and immediate injury to an interest arguably within the "zone of interest to be regulated or protected." See Televisual Communications, Inc. v. Department of Labor and Employment Security, 667 So. 2d 372, 374 (Fla. 1st DCA 1995); Ward v. Board of Trustees of the Internal Improvement Trust Fund, 651 So. 2d 1236 (Fla. 4th DCA 1995). It appears from a review of Petitioner's petition that, in connection with its challenge to the proposed amendment of Rule 59G-6.040, Florida Administrative Code, Petitioner has alleged facts sufficient to make such a showing.
>
> The current version of Rule 59G-6.040, Florida Administrative Code, establishes the reimbursement plan and payment methodology presently used to calculate reimbursement

> payments made for ICF/MR-DD services provided by Petitioner and all other providers of such services, both public and private. If the proposed amendment of Rule 59G-6.040, Florida Administrative Code, along with proposed new Rule 59G-6.045, Florida Administrative Code, were adopted, Petitioner and other private providers would be reimbursed, not in accordance with Rule 59G-6.040's reimbursement plan and payment methodology as they are at present, but, instead, pursuant to a reimbursement plan and payment methodology that would be (according to the allegations made in Petitioner's petition) more restrictive and less favorable to providers. The adoption of the proposed amendment of Rule 59G-6.040, Florida Administrative Code, coupled with the adoption of proposed new Rule 59G-6.045, Florida Administrative Code, therefore, would alter the status quo in such a manner as to "substantially affect" Petitioner.

On October 20, 1998, Petitioner filed a Memorandum of Law in Support of Petition Challenging Agency for Health Care Administration Rules. In its memorandum of law, Petitioner made the following "Legal Arguments":

> A. The proposed rules violate state and federal law as they are arbitrary and capricious because they do not take into consideration the relevant factors set forth in 42 USC Section 1396a(a)(30)(A).
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> B. The proposed rules violate federal law
>
> 1. The proposed rules violate 42 USC Section 1396a(a)(13)(A).[1]
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> 2. The Agency has failed to comply with the notice requirements of 42 CFR Section 447.205(a).[2]
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> 3. The proposed rules violate 42 USC Section 1396a(a)(30)(A).[3]

4. The proposed rules violate the Americans with Disabilities Act.

5. The proposed rules violate a federal district court order directing payment of all private providers of public facilities at the full Medicaid rate for a period of 25 years.

C. The proposed rules violate state law.

1. The proposed rules are vague and fail to establish adequate standards for Agency decisions and/or vest unbridled discretion in the Agency.

As noted above, the final hearing in this case was held on October 21 and 22, 1998. The following witnesses testified at hearing: Leslie W. Leech, Jr., Petitioner's President and CEO; Rachel Johnson, Petitioner's Vice President of Operations; Dr. James Weeks, Petitioner's Vice President and Secretary/Treasurer; and John Owens, Respondent's representative at hearing. In addition, numerous exhibits were offered and received into evidence.

At the close of the evidentiary portion of the hearing on October 22, 1998, the undersigned established, pursuant to the parties' request, the following deadlines for the filing of post-hearing submittals: Respondent's initial proposed final order-- ten days from the date of the filing of the hearing transcript with the Division; Petitioner's proposed final order-- ten days from the date of service of Respondent's initial proposed final order; and Respondent's supplemental proposed final order-- five days from the date of service of Petitioner's proposed final order. The parties agreed that the undersigned would have 30 days from the date of the filing of Respondent's supplemental proposed final order to issue a final order in this case.

The transcript of the final hearing in this case was filed with the Division on November 16, 1998. Respondent's initial proposed final order, Petitioner's proposed final order, and Respondent's supplemental proposed final order were filed with the Division on November 30, 1998, December 10, 1998, and

December 22, 1998, respectively.[4] These post-hearing submittals have been carefully considered by the undersigned.[5]

FINDINGS OF FACT

Based upon the evidence adduced at hearing and the record as a whole, the following findings of fact are made:

Petitioner

1. Petitioner is a nonprofit Florida corporation.

2. It operates as a charity providing services to individuals (both children and adults) with developmental disabilities in Florida and elsewhere.

3. It provides services to Florida residents in various Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs[6]) that it owns and/or operates, including state-owned "cluster" facilities each consisting of three eight-bed buildings sharing a common campus.

4. These "cluster" facilities were created by the state as an alternative to the large state-owned and operated institutions.[7]

5. Petitioner renders services in these "cluster" facilities pursuant to contracts it has entered into with the state.

6. All of the facilities that Petitioner operates in the state, regardless of size, are located in residential neighborhoods.

7. The residents of these facilities suffer from mental

retardation and various other disabilities, including cerebral palsy, autism, spina bifida and epilepsy. Many require constant supervision, attention, and care, as well as aggressive intervention and treatment.

8. The services that Petitioner provides are designed to assist these individuals in reaching their full potential.

9. All of the residents of Petitioner's ICF/DDs in Florida are Medicaid-eligible.[8]

10. Petitioner receives Medicaid payments for providing services to these residents.

11. These Medicaid payments have been insufficient to cover Petitioner's costs. (Other private ICF/DD providers[9] in Florida have experienced similar funding shortfalls.[10] From 1991 to 1996, private ICF/DD providers in Florida, as a group, received $4,652,312.00 less in Medicaid payments than they spent to provide services.)

12. Petitioner has engaged in fund-raising activities to supplement the Medicaid payments it receives.

13. While these fund-raising activities have generated additional monies, Petitioner, nonetheless, to the detriment of residents, has had to make reductions in the amount it spends for their treatment and care.

14. Recently, Petitioner experienced significant difficulty meeting its payroll, and was forced to obtain a bank loan to pay its employees the monies it owed them.

Current Medicaid Reimbursement Methodology

15. Petitioner and all other ICF/DD providers, including the state, are currently reimbursed for providing Medicaid-covered services at their facilities in accordance with the methodology set forth in "Florida Title XIX Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled Reimbursement Plan, Version VI, November 15, 1994" (Version VI of the Plan). Version VI of the Plan is incorporated by reference in Rule 59G-6.040, Florida Administrative Code,[11] which provides as follows:

> 59G-6.040 Payment Methodology for ICF/MR-DD Services.
>
> Reimbursement to participating ICF/MR-DD facilities for services provided shall be in accord with the Florida Title XIX ICF/MR-DD Reimbursement Plan Version VI, November 15, 1994, and incorporated herein by reference. A copy of the Plan as revised may be obtained by writing to the Office of the Medicaid Director, P.O. Box 13000, Tallahassee, Florida 32399-0700.
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> Specific Authority 409.919 FS.
> Law Implemented 409.908 FS.
> History--New 7-1-85, Amended 2-25-86, Formerly 10C-7.491, Amended 11-19-89, 8-14-90, 12-26-90, 9-17-91, 1-27-94, Formerly 10C-7.0491, Amended 11-15-94.

16. Pursuant to Version VI of the Plan, "[r]eimbursement rates [are] established prospectively for each individual provider based on the most historic costs, but historic costs [are] limited to allowable percentage increases from period to period."

17. "Reimbursement rates [are] calculated separately for two classes . . . based on the four levels of ICF/MR-DD care," Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical, with the former two (Developmental Residential and Developmental Institutional) constituting one class and the latter two (Developmental Non-ambulatory and Developmental Medical) constituting the other class.

18. "The four components [of a provider's reimbursement rate] are operating costs, resident care costs, property costs, and return on equity costs or use allowance, if applicable. Inflation allowances used in the rate setting process [are] applied to the operating and resident care cost components independently for the two reimbursement classes."

19. Section V.M. of Version VI of the Plan, which provides as follows, describes the "target rate of inflation" feature of the reimbursement methodology, which is a cost containment feature designed to promote economy and efficiency:

> The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount with exceeds 1.786 times the average percentage of increase in the Florida ICF/MR-DD Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operation or resident care exceeds the target

> rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem cost shall be used for prospective rate setting purposes and for future target rate comparisons.

20. Notwithstanding its name, the "Florida ICF/MR-DD Cost Inflation Index" is based upon a national (rather than a Florida-specific) market basket index.[12]

21. Section IV.K. of Version VI of the Plan provides for "incentive payments" to be made to providers who are not "out of compliance with any Condition of Participation" and "whose annual rates of cost increase for operating cost or resident care costs from one cost reporting period to the next are less than 1.786 times the average cost increase for the applicable period documented by the ICF/MR-DD Cost Inflation Index." According to the language contained in this section, its provisions are designed to "encourage high quality care while containing costs."

22. Version VI of the Plan also has a "rebasing" feature, which operates to increase reimbursement rates periodically (no less than once every five years). This "rebasing" feature is described in Section V.B.9 as follows:

> Rebasing of the operating and resident care component per diems shall occur every five (5) years or whenever fifty percent (50%) of private providers are reimbursed less than reported, allowable costs (whichever occurs first). In detail, rebasing will occur in the rate semester in which fifty percent (50%) or more of the private providers'

> operating and resident care per diem rate (combined) are less than the operating and resident care inflated costs (combined)(inflated at 1xNational DRI as Florida weighted) based upon eligible cost reports, or each five (5) years counting from October 1, 1991 (1.e, the first rebasing occurring on October 1, 1996) whichever occurs first. The rebasing calculation methodology shall be identical to that used for the October 1, 1989 rate semester rebasing (Section V.A.1.5.) except that rebasing shall occur only for providers whose inflated combined operating and resident care rate does not cover one hundred (100%) of their combined operating and resident care inflated costs. Individual providers which would qualify for rebasing based on April 1, 1991 rates shall be rebased effective July 1, 1991.

23. Version VI of the Plan also provides for "interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process . . ., as well as changes in a provider's allowable cost basis." These provisions promote quality of care inasmuch as they authorize reimbursement for certain costs "necessary to meet existing state or federal requirements," notwithstanding the cost containment features contained elsewhere in the Plan. They are found in Section IV.G.1 through 6, which provide as follows:

> 1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital cost, request for component interim rate shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (1), (2), and (3) above must be submitted within 60 days after costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request subsequent to

June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and the actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider . . . .

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

24. Sections VI. and VII. of Version VI of the Plan are entitled "Payment Assurance" and "Provider Participation," respectively, and provide as follows:

> VI. Payment Assurance
>
> The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in the Florida Title XIX ICF/MR-DD Reimbursement Plan.
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> VII. Provider Participation
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> The plan is designed to assure adequate participation of ICF/MR-DD providers in the Medicaid Program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

ICF/DD Reimbursement Prior to 1989

25. Originally, ICF/DD providers in Florida were reimbursed for providing services to the Medicaid beneficiaries in their facilities pursuant to the same methodology used to reimburse nursing home operators. It subsequently was determined, however, that, because of the differences between ICF/DDs and nursing homes and their respective populations,[13] a separate methodology for ICF/DDs was warranted in order to ensure that reimbursement rates for ICF/DD providers were adequate. Such a separate methodology for ICF/DDs (ICF/DD Methodology) was created in 1984.

26. The new ICF/DD Methodology did not include a rebasing provision, and its implementation did not result in an

elimination of ICF/DD underfunding. In fact, from 1984 to 1989, most ICF/DD providers, including the state, suffered "tremendous losses."

27. In 1989, a rebasing provision was added to the ICF/DD Methodology.

28. In less than 24 months after the addition of this provision, however, more than half of the ICF/DD providers were spending more on providing ICF/DD services than they were being reimbursed.

United States District Court for the Southern District Court of Florida Case No. 89-0984

29. Petitioner is now, and has been at all times material to the instant case, a member of the Florida Association of Rehabilitation Facilities, Inc. (FARF), a trade association representing non-profit corporations that own and/or operate intermediate care facilities for the developmentally disabled.

30. In 1989, FARF and its members (Plaintiffs), including Petitioner, filed suit in the United States District Court for the Southern District Court of Florida (Case No. 89-0984) challenging the manner in which Florida reimbursed FARF members for the provision of Medicaid-covered services.

31. In May of 1991, Respondent's predecessor, in an effort to address the issues raised in the FARF lawsuit, announced that it was making revisions in the ICF/DD Methodology. These revisions took effect July 1, 1991.

32. On September 11, 1991, United States District Court

Judge Lenore C. Nesbitt, acting upon the Plaintiffs' motion, issued an Order Granting Preliminary Injunction in Case No 89-

0984. Judge Nesbitt's order contained the following "findings of facts":

> Plaintiffs are a group of non-profit corporations providing health care services to mentally retarded individuals in intermediate care facilities ("ICF/MR"), and a trade association representing that group. Defendants are the Florida Department of Health and Rehabilitative Services ("HRS") and two of its officials. At the request of the State of Florida, Plaintiffs provide treatment for mentally retarded individuals, 99%-100% of whom are Medicaid-eligible, in numerous facilities in the state. Certain Plaintiffs both own and operate the ICF/MRs. Others only operate the facilities, which are on land owned by the State. This latter group of facilities are known as "cluster facilities."
>
> Because the State of Florida has chosen to receive federal funds by participating in the Medicaid program, it must comply with the requirements of the federal act. One requirement is that the State develop a reimbursement plan for providers of ICF/MR services. As described below, the state need not reimburse all actual costs of the providers; it must only pay rates which are "reasonable and adequate" for an efficient provider to provide care in compliance with applicable state and federal laws and quality and safety standards.
>
> HRS reimburses Plaintiffs in the following manner: Operators of cluster facilities are paid pursuant to a fixed-rate contract, _not_ pursuant to any reimbursement plan. Also, HRS' obligations under the contract are expressly made conditional on sufficient appropriations by the state legislature. Operators of non-cluster facilities are reimbursed pursuant to a plan formulated by the state. As is true with most state plans, and is permitted by the Medicaid Act, HRS' plan determines cost on a _prospective_ basis. That is Plaintiffs are paid based on what their services should cost not on what they

have actually spent. See Wilder v. Virginia Hosp. Assn., 110 S.Ct 2510, 2516 n.7 (1990).

The plan reimburses non-cluster providers as follows: Providers get either last year's actual costs or last year's "target limit cost" (i.e. the previous year's costs plus allowed inflation plus 1.5%), whichever is lower, plus one times the "Modified DRI Nationwide Nursing Home Costs Index." By contrast, operators of "skilled nursing facilities" were provided an inflation increase equivalent to two times the DRI Index.

Significantly, there is no periodic readjustment of the target limit. As a result, efficient providers whose necessary costs are consistently greater than their target limit will continue to be under-reimbursed. Further, providers who keep their costs below the target limit are rewarded with a penalty: their target limit for the following year is reduced.[14]

Plaintiffs assert three challenges to Florida's medicaid reimbursement system. In count I, the substantive challenge to the state's plan, Plaintiffs allege that HRS' plan does not meet the substantive requirement of the Boren Amendment to the Medicaid Act. That is, it does not provide for rates which are "adequate and reasonable" to meet those costs which must be incurred by efficient providers of services in conformity with applicable federal and state laws, regulations, and quality and safety standards.

In support of this count, Plaintiffs have submitted several affidavits stating that they and every other provider in the state, except one, continually operate at a large loss because their costs substantially exceed the amounts reimbursed under the plan.[15] Neither is it genuinely disputed that the current situation impacts on quality of care.[16]

Count II, the equal protection claim, alleges that the state's decision to reimburse "skilled nursing facilities" at two times the DRI inflation rate while reimbursing ICF/MR providers at just one times the DRI rate is arbitrary, without justification, and hence violative of the Constitution.

Count III alleges and it is undisputed that HRS payment to cluster providers via a fixed-rate contract instead of pursuant to a plan, while at the same time receiving federal funds under the Medicaid Act, violates federal law. Further, Plaintiffs challenge HRS' refusal, prior to the filing of the pending motion, to amend the cluster contracts to cover unexpected and unavoidable interim cost increases, such as increases in worker's compensation insurance rates. As a result of these refusals, Plaintiffs have suffered financially relative to those reimbursed pursuant to a plan. Plaintiffs' evidence also indicates that, because of these consistent and substantial unreimbursed costs, operators of cluster facilities may be unable to continue providing care in the future.[17]

Defendants' evidence consists of allegations that Plaintiffs' financial difficulties have resulted from past poor management decisions, specifically from their past failure to devote sufficient resources to the wages of their direct care staff.

Defendants' evidence also raises a factual dispute as to the financial loss to cluster providers as a result of being paid pursuant to a fixed-rate contract.

Otherwise, Defendants do not seriously dispute most of the facts set forth in Plaintiffs' affidavits. Instead, Defendants' submissions consist primarily of argument: they comment on Plaintiffs' evidence and ask the Court to draw the conclusion that (1) their plan reasonably and adequately reimburses the truly efficient provider, and that (2) Plaintiffs' problems are the result

> of inefficiencies and management mistakes
> unrelated to deficiencies in the plan.

33. After setting forth these "findings of fact," Judge Nesbitt, in her order, engaged in a discussion explaining why it appeared that Plaintiffs were entitled to a preliminary

injunction as to Counts I and III of their complaint. In "conclusion," Judge Nesbitt stated the following:

> For these reasons, Plaintiffs' Motion for Preliminary Injunction is GRANTED as to Counts I and III. Accordingly, effective September 4, 1991, Defendants are hereby
>
> ENJOINED from inadequately reimbursing providers of care in the ICF/MR program. Defendants are further
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> ENJOINED from paying providers for services at ICF/MR cluster facilities in a manner other than as provided for in a rate plan, and shall commence paying each provider of ICF/MR services at cluster facilities the full Medicaid rate for that facility, and shall afford each provider at cluster facilities all rights and protections accompanying a rate plan governing ICF/MR facilities.
>
> Though the Court may make interim modifications to the state's current plan, . . . the Court shall not do so at this time. In the spirit of the Boren Amendment's goal of permitting states maximum flexibility in formulating plans for reimbursement, Defendant shall be permitted to file, on or before October 4, 1991, a plan which complies with the substantive requirements of 42 U.S.C. Section 1396a(a)(13). See Wilder v. Virginia Hosp. Assn., 110 S.Ct. 2510, 2517 & 2525 (1990). The rates of reimbursement established under the plan ultimately approved by the Court shall be retroactive to September 4, 1991. The parties are directed to cooperate in formulating an acceptable plan to be presented to this court.[18]

34. The Order Granting Preliminary Injunction entered by Judge Nesbitt has not been vacated, rescinded, set aside or modified.

35. On November 14, 1991, Judge Nesbitt issued an Order on Motion for Civil Contempt and Sanctions in Case No. 89-0984, which provided as follows:

> THIS CAUSE came on before the Court on Plaintiffs' Motion for Civil Contempt and Sanctions and after agreement of counsel for the respective parties before Magistrate Judge Turnoff and submission by all parties of the attached joint proposal,
>
> IT IS ORDERED AND ADJUDGED that the attached document is adopted and approved by the Court as its Order on Motion for Civil Contempt and Sanctions and the parties and their agents and successors are hereby ordered to comply with the terms hereof commencing on November 1, 1991.

36. The "attached joint proposal" which Judge Nesbitt "adopted and approved" provided as follows:

> BASIS FOR AGREEMENT TO DISMISS MOTION FOR CONTEMPT
>
> 1. Interim rates for Sunrise OK (Weeks attachment)
>
> 2. Depreciation and Maintenance
>
> a. HRS agrees to pay the full Medicaid rate in the current Medicaid rate plan to cluster operators.
>
> b. Cluster operators agree to use amounts in the full rate devoted to depreciation for repair of the facility and replacement (if necessary) of the equipment of facility. HRS and clusters shall agree on said repairs and replacements and shall prioritize any licensure deficiencies for replacement or repair. To the extent there is no necessity for repair of the facility or replacement of equipment, all funds shall revert to HRS/Developmental Services. The amount of depreciation in any given year shall be as

computed in the cost report and in accordance with the rate Plan.

c. HRS agrees to retain all liability for repair of the facility and replacement equipment (if any) in excess of those items handled under section 2.

d. Cluster operators and HRS agree that maintenance funds in the full rate, which are attributable to HRS costs incurred in the facility, shall be sent to HRS for continuation of maintenance, or may be retained by cluster and HRS relieved of responsibility for maintenance.

3. Cluster operators are not obligated to assume duties and obligations/ responsibilities in their contracts with HRS district offices that are in excess of those required of an ordinary ICF/MR provider.

4. Pay 6+% retroactive to July 1 by November 30.

5. Agree to pay minimum of May 17 agreement or full rate, whichever is higher, for 1 year, ending June 30, 1992.

6. Agree to pay minimum of May 17 agreement or full rate, whichever is higher, for 1 year, ending June 30, 1992.

6. Agree to pay minimum of May 17 or full rate, whichever is higher, for an additional 4 year period, ending June 30, 1996 subject to legislative appropriation each year. Absent legislative approval, cluster entitled to full rate without depreciation and expense deduction or restrictions contained herein.

7. HRS agrees to seek legislative appropriations, for additional funds, if necessary, in excess of total Medicaid rate, to fund those additional revenues, required per #5 for each year until 1996.

8. These term[s] supplement and do not abrogate May 17 except annual renewal replaced with 5 year contract. Each

subsequent contract shall be for 5 years. Defendants shall be entitled in that year to renegotiate the contract or bid-out the contract.

Under 2B. Right to Renewal of the Stipulation of Settlement lines 8 through 12 beginning with "Cluster" and ending with "Stipulation" shall be stricken. In additions lines 6 through 19 on Page 7 shall be stricken beginning with "Defendants" and ending with "1991."

8. See attached. (Sic. #8 now included in running text.)

9. If depreciation of funds are available after expenditures have been made for necessary repairs and replacement, HRS and cluster operator shall agree to deposit such funds into a reserve fund, to be held by the operator, to fund necessary repairs and replacement in future years, particularly long term repairs unlikely to appear on a regular basis. Funds held in reserve by the operator for long term repair or replacement which are not expended by the end on the 5 year contract period shall revert to the Department, unless the Department renews the contract with the same operator, or funds are transferred to new provider.

10. At the end of each 5 year contract with cluster, the contract may be renewed with the current cluster operator, or bid out.

11. When contracts are renewed or bid out, the terms shall be for the full Medicaid rates.

12. Funds appropriated in F.Y, 1991-92 for repairs and replacement shall be promptly disbursed.

(Note: The numbering system on my original copy reflects changes made after copying had taken place, but before signature. Thus the copy shows an 8. and 9., which have been deleted on the original signed agreement.

Also the copy shows number 10.-14 which have been renumbered on the original 8.-12.)

(Weeks Attachment)

1. The interim rate request filed for the McCauley, Mahan, Dorchester, Bayshore, Green Tree Court and St. Petersburg on June 17, 1991 will be approved for all six clusters. Reimbursement for the interim rate increase shall be paid to Sunrise beginning 60 days prior to the date of filing and the interim shall be settled based on the June 30, 1991 cost reports for each of these clusters. The level of interim rate increase shall be per data and calculations provided the Department with Sunrise's July 31, 1991 letter to Ms. Joyce Barrington. Procedure used for this interim shall be in compliance with the current Florida Title XIX ICF/MR-DD Reimbursement Plan and current procedures for interim rates to include inflation on the interim rate component effective 7/1/91 through 3/30/92.

37. Case No. 89-0984 is still pending (but before Judge Michael Moore).

Doe v. Chiles

38. In March of 1992, FARF became involved in another federal lawsuit against the state, when it, along with United Cerebral Palsy, Inc., and various Florida residents who had been placed on waiting lists for entry into an ICF/DD, filed a 1983 action in the United States Court for the Southern District of Florida (styled Doe v. Chiles) claiming that the state was causing unreasonable delays in the provision of ICF/DD services.

39. In December of 1992, FARF and United Cerebral Palsy, Inc., were dismissed as plaintiffs.

40. On July 22, 1996, Judge Wilkie D. Ferguson, Jr.,

granted the remaining plaintiffs' motion for summary judgment, holding:

> Section 1396a(a)(8) of the Medicaid (A)ct, specifically the reasonable promptness clause, is enforceable under 42 U.S.C. Section 1983. "Medical assistance under the plan" has been defined as medical services. The (S)tate is obliged to furnish medical services, however, only to the extent that such placements are offered in the Federal Health Care Financing Agency ("HCFA") approved State plan. Once a state elects to provide a service, that service becomes part of the state Medicaid plan and is subject to the requirements of Federal law.
>
> At oral argument on this issue, Defendants conceded that Florida's [HCFA] State approved plan does provide for placement in ICF/MR facilities. Further, Defendants have not disputed the facts alleging the [S]tate's failure to conform with the provisions set forth in that statute, which the Court construes as an admission of unreasonable delays in placing developmentally disabled persons into ICF/MR facilities.

41. On August 26, 1996, a magistrate judge signed a report recommending that Judge Ferguson grant the plaintiffs' motion to certify as a class "all those developmentally disabled persons who have not received prompt [ICF/DD] placement."

42. After conducting a hearing on August 28, 1996, Judge Ferguson entered a final judgment, ordering that the state "shall, within 60 days of the date of this Order, establish within the State's Medicaid Plan a reasonable waiting list time period, not to exceed ninety days, for individuals who are eligible for placement in [an ICF/DD]."

43. The state appealed the final judgment.

44. On February 26, 1998, the Eleventh Circuit, in an opinion reported at 136 F.2d 709 (11th Cir. 1998), affirmed the judgment.

Chapter 96-417, Laws of Florida

45. In 1996, the Florida Legislature passed House Bill No. 1621 (Chapter 96-417, Laws of Florida), Sections 4, 6, 11, 12, 13, 14, 15, 16 and 17 of which provided, in pertinent part, as follows:

> Section 4. Subsections (8) and (14) of section 409.906, Florida Statutes, are amended to read:
>
> 409.906 Optional Medicaid services. ---
>
> Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Optional services may include: . . .
>
> (14) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED ~~MENTALLY RETARDED~~ SERVICES. For the purposes of Medicaid reimbursement, "intermediate care facility for the developmentally disabled services" means services provided by a facility which is owned and operated by the state and to which the agency may pay for health-related

care and services provided on a 24-hour-a-day basis, for a recipient who needs such care because of a developmental disability or related condition. ~~The agency may pay for health related care and services provided on a 24-hour-a-day basis by a facility licensed under chapter 393, to a recipient who needs such care because of his mental or physical condition~~.[19] . . .

Section 6. Section 409.908, Florida Statutes is amended to read:

409.908 Reimbursement of Medicaid providers.

Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled ~~mentally retarded~~ licensed under chapter 393 must be made prospectively. . . .

Section 11. (1) The Legislature finds:

(a) That noninstitutional home and community-based services are a cost-effective and appropriate alternative to institutional care for many individuals who would otherwise be served in institutional settings;

(b) That the Intermediate Care Facility for the Developmentally Disabled program is an optional institutional service authorized by Title XIX of the Social Security Act and that this act encourages states to develop and utilize alternatives to optional institutional services for Medicaid clients through authorization of waivers that allow for federal financial participation in the provision of services in noninstitutional settings for clients who are eligible for Medicaid-reimbursed institutional services;

(c) That utilization of noninstitutional funding mechanisms for individuals residing outside of state-owned-and-operated institutions allows individuals to be appropriately served at less cost than is possible through the Intermediate Care Facility for the Developmentally Disabled program;

(d) That federal regulations diminish the ability of the state to manage resources currently used to reimburse privately owned or operated intermediate care facilities for the developmentally disabled to enable the most cost-effective utilization of resources appropriated to programs that serve individuals with developmental disabilities;

(e) That there are fundamental differences in the respective roles of private and public facilities that serve individuals with developmental disabilities and that these differences justify funding private and public facilities through different funding mechanisms;

(f) That there is a critical state need to continue financing institutional services

provided in state-owned-and-operated facilities for the developmentally disabled through the Intermediate Care Facility for the Developmentally Disabled program to provide for the adequate care of the clients who reside in these facilities; and

(g) That the most appropriate and cost-effective care for state-supported clients who reside in privately owned or operated residential facilities for individuals with developmental disabilities is provided through community-based, noninstitutional service delivery models that are financed through noninstitutional financing mechanisms.

(2) In accordance with the findings in subsection (1), it is the intent of the Legislature that, in order to both reduce the cost of serving individuals with developmental disabilities and provide appropriate alternative services to institutional care, privately owned or operated facilities authorized to receive reimbursement through the Medicaid Intermediate Care Facility for the Developmentally Disabled program on June 30, 1996, shall no longer be reimbursed through that program but may continue to serve clients through noninstitutional service arrangements that are financed through noninstitutional funding mechanisms. It is further the intent of the Legislature that individuals who reside in state-owned-and-operated intermediate care facilities for the developmentally disabled shall continue to receive services financed through the Medicaid Intermediate Care Facility for the Developmentally Disabled program.

Section 12. The Agency for Health Care Administration shall issue a license as a home for special services to each facility desiring such licensure, if the facility was eligible to receive reimbursement through the Intermediate Care Facility for the Developmentally Disabled program on June 30, 1996. Individuals with developmental disabilities who reside in homes for special

services licensed pursuant to this section may receive services reimbursed through the home and community-based services waiver, provided all other Medicaid eligibility criteria are satisfied. A license granted pursuant to this section shall be valid until the expiration of the facility's Intermediate Care Facility for the Developmentally Disabled license. The Agency for Health Care Administration shall develop standards for facilities licensed pursuant to this section which shall include appropriate sanctions for noncompliance with the standards and shall specify the terms for renewal of licenses. Any license granted pursuant to this section shall be contingent upon the facility allowing access to the Agency for Health Care Administration to conduct inspections to ensure compliance with standards.

Section 13. Subsection (29) of section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.- For purposes of this chapter:

(29) "Intermediate care facility for the developmentally disabled" or "ICF/DD" means a state-owned-and-operated residential facility licensed in accordance with state law, and certified by the Federal Government pursuant to the Social Security Act, as a provider of Medicaid services to persons who are mentally retarded or who have related conditions. The capacity of such a facility shall not be more than 120 clients.

Section 14. Section 393.067, Florida Statutes, is amended to read:

393.067 Licensure of residential facilities and comprehensive educational programs.-

~~(18) In addition to the requirements in subsection (4), the initial license application for an intermediate care facility for the developmentally disabled of six beds or less shall also include:~~

~~(a) The provider's proposal, on forms provided by the department, including a pro forma budget which shall also serve as the basis for establishing an initial interim Medicaid reimbursement rate.~~

~~(b) Approval and selection of the provider's proposal by the district and the Developmental Services Program in accordance with paragraph (20)(c).~~

~~(19) The initial license application shall be valid while the provider develops the facility in compliance with the conditions of the approved proposal.~~

~~(20) The department shall only accept proposals for intermediate care facilities for the developmentally disabled of six beds or less in response to the publication of projected bed need.~~

~~(a) Projected bed need shall be published by the department and shall identify:~~

~~1. The district in which the beds are to be located.~~

~~2. The maximum per diem cost which shall be in accordance with the Florida Title XIX ICF/MR Reimbursement Plan.~~

~~3. The maximum size of the facility.~~

~~4. The level of care of clients to be served, including demographic and programmatic characteristics of the client population. Projected bed need shall be directed towards clients who have severe disabilities, who have extensive service needs, who require extensive active treatment services, and who can only be adequately served in a cost-effective manner in an intermediate care facility for the developmentally disabled.~~

~~(b) Projected bed need shall be determined by the department on the basis of client need for extensive active treatment services that can only be delivered in a cost-effective~~

~~manner in an intermediate care facility for the developmentally disabled.~~

~~(c) The department shall approve and select from provider proposals that respond to published projected bed need, based on the following weighted criteria in order of importance:~~

~~1. Adequacy and quality of services that address the published bed need projections, especially the client demographic and programmatic characteristics.~~

~~2. Completeness of the proposal and adherence to timeframes.~~

~~3. Demonstration of financial ability to operate the facility in relation to published bed need projections.~~

~~4. Appropriateness of per diem cost to provide quality services.~~

~~(21) Any license granted for intermediate care facilities for the developmentally disabled under the provisions of subsections (18) and (20) shall be valid only while the provider operates the facility in compliance with the conditions in the proposal that were approved by the department, as well as with all other applicable laws, rules, and regulations related to the operation of such facilities.~~

Section 15. (1) Section 393.16, Florida Statutes, is hereby repealed.[20]

(2) Any cash balance remaining in the Intermediate Care Facilities Trust Fund shall be transferred to the Community Resources Development Trust Fund.

Section 16. Notwithstanding any other provision of law, or this act to the contrary, the Agency for Health Care Administration may continue to reimburse private intermediate care facilities for the developmentally disabled through the Intermediate Care Facility for the

> Developmentally Disabled program through August 30, 1996, if requested by the Secretary of Health and Rehabilitative Services to ensure the safety and well-being of clients.
>
> Section 17. This act shall take effect July 1, 1996, or upon becoming a law, whichever is later; however, if this act becomes a law after July 1, 1996, it shall operate retroactively to July 1, 1996.

46. Chapter 96-417, Law of Florida, became a law without the Governor's approval on June 7, 1996.

Cramer v. Chiles

47. Chapter 96-417, Florida Statutes, was challenged in the United States District Court for the Southern District of Florida in the case of Cramer v. Chiles, Case No 96-6619, which was assigned to Judge Ferguson.

48. On August 28, 1996, Judge Ferguson issued an Order on Motion for Preliminary Injunction in Case No. 96-6619, which provided as follows:

> THIS CAUSE came before the Court for oral argument August 28, 1996 on Plaintiffs' Emergency Motion for Preliminary Injunction. Plaintiffs request the Court stay the effective date of Chapter 96-417, Public Laws, which is scheduled to go into effect August 30, 1996. The enactment would eliminate all private intermediate care facilities for the developmentally disabled[21] ("ICF/DDs") in Florida, reducing the number of ICF/DD placements available by nearly 2,200.
>
> This Court previously determined in Doe v. Chiles, Case No. 92-589-CIV-Ferguson, that the State of Florida is obligated to provide placement of eligible individuals in ICF/DDs. Accordingly, in the absence of a transitional

> plan and showing that the State's proposed revised plan, under the new legislation, will adequately provide ICF/DD placements for eligible persons in Florida, there is a likelihood that Plaintiffs will succeed on the merits. To allow the substantial change scheduled for August 30, 1996, prior to the submission to, and approval by, the Federal Health Care Financing Agency ("HCFA") of an alternative plan which satisfies the State's obligations to beneficiaries under the existing plan, would cause irreparable harm to individuals currently provided care in those facilities. There must be a period and a plan for transition which will insure that services to the entitled recipients are not substantially impaired. The Plaintiffs have made a sufficient showing that there is no adequate legal remedy. Accordingly, it is
>
> ORDERED AND ADJUDGED that the Plaintiffs' motion for preliminary injunction is GRANTED, and the State shall continue to provide the current funding for 100% of cost reimbursements to private ICF/DD facilities until such time as a revised plan is presented and approved by HCFA. The new plan, for fairness considerations, shall disclose criteria to be used by the State in its reassessments for continued institutional care eligibility.
>
> Time is of the essence, as budgetary constraints dictate that a plan must be approved well before the end of the fiscal year, June 30, 1997. It is thus incumbent on all parties to move expeditiously.

49. On October 13, 1998, Judge Ferguson issued an Order on Defendants' _Ore Tenus_ Agreed Motion to Revive Statutory Scheme, which provided as follows:

> THIS MATTER came before the Court upon Defendants' _Ore Tenus_ Agreed Motion to Revive Statutory language in Chapters 393 and 409, FLORIDA STATUTES (1995), as they existed prior to the enactment of Chapter 96-417, LAWS OF FLORIDA, and the Court being fully

> advised in the premises and having considered the entire record of the case, for good cause shown, it is hereby
>
> ORDERED AND ADJUDGED the Motion is Granted <u>nunc</u> <u>pro</u> <u>tunc</u> to the date of the entry of oral Order on Summary Judgment on January 9, 1998.

<u>Chapter 97-260, Florida Statutes</u>

50. Following the initiation of the challenge to Chapter 96-417, Laws of Florida, the Florida Legislature further addressed the "transition from funding through the Intermediate Care Facility for Developmentally Disabled Program to noninstitutional funding" by enacting Chapter 97-260, Laws of Florida, section 4 of which provided as follows:

> Report required; department to notify Legislature and develop plan if judicial decisions result in spending requirements in excess of appropriations.-
>
> (1) The Department of Children and Family Services shall develop individual support plans for the approximately 2,176 persons directly affected by the transition from funding through the Intermediate Care Facility for Developmentally Disabled Program to noninstitutional funding. The individual plans shall provide for appropriate services to each affected individual in the most cost-effective manner possible. The department shall report the projected aggregate cost of providing services by fund source through the individual plans to the Office of Planning and Budgeting, the Senate Ways and Means Committee, and the House Health and Human Services Appropriations Committee by September 30, 1997. The aggregate costs reported shall be based on typical industry rates and shall not include special adjustments for property costs or other additional costs unique to any individual provider or type of provider. The department

> may, however, report any such costs separately. The report must further provide detailed information on department efforts to maximize Medicare and other funding available outside the Developmental Services Program and the use of generic community resources along with a calculation of the value of such resources. The report must also include a summary of the department's progress in recruiting alternative providers in the event that any current providers decide to discontinue services to clients or cannot provide quality services within the anticipated rate structure.
>
> (2) If judicial decisions are continued or rendered that the Department of Children and Family Services feels will require spending in excess of the amounts budgeted for Developmental Services, the department shall immediately notify the Chairs of the Senate Ways and Means Committee, the House Fiscal Responsibility Council, and the House Health and Human Services Appropriations Committee. Within 1 week after providing notification pursuant to this subsection, the department shall submit a spending plan that addresses the projected deficit.
>
> (3) This section is repealed July 1, 1999.

Boren Amendment Repeal

51. In the Balanced Budget Amendment of 1997 (more specifically, Section 4711(a)(1) thereof), the United States Congress repealed the Boren Amendment to the Medicaid Act, which Judge Nesbitt had referred to in her Order Granting Preliminary Injunction in United State District Court for the Southern District of Florida Case No. 89-0984. The Boren Amendment required, in pertinent part, that a state plan for medical assistance[22] provide for "payment of . . . the hospital services, nursing facility services, and services in an intermediate care

facility for the mentally retarded provided under the plan through the use of rates . . . which the State finds, and makes assurances to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." Section 4711(a)(1) of the Balanced Budget Amendment of 1997 eliminated this requirement (which was codified in 42 U.S.C. 1396a(a)(13)) and replaced it with the requirement that a state plan:

> (13) provide--
>
> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

52. Subsection (b) of Section 4711 of the Balanced Budget Amendment of 1997 provided as follows:

> (1) STUDY.--The Secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).
>
> (2) REPORT.--Not later than 4 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

53. Subsection (d) of Section 4711 of the Balanced Budget Amendment of 1997 provided as follows::

> (d) EFFECTIVE DATE.--This section shall take effect on the date of the enactment of this Act and the amendments made by subsections (a) and (c) shall apply to payment for items and services furnished on or after October 1, 1997.

54. Following the passage of the Balanced Budget Act of 1997, the Health Care Finance Agency (HCFA), a federal agency which assists in the administration of the federal Medicaid program,[23] sent the following letter, dated December 10, 1997, to state Medicaid directors concerning the repeal of the Boren Amendment:

> This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA). Section 4711 of BBA repeals Sections 1902(a)(13)(A), (B), and (C) of the Social Security Act (the

Act), requires states to implement a public process when changes in payment rates or payment methodologies are proposed, and applies to payments for items and services furnished on or after October 1, 1997. (See Enclosure 1 for background on Section 4711.)

Section 4711 of BBA replaced the Boren requirements with a new section 1902(a)(13)(A) of the Act, which requires states to (a) use a public process for determining rates, (b) publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates, and (c) give interested parties a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications. In the case of hospitals, such rates must take into account the situation of hospitals which serve disproportionate number of low-income patients with special needs.

The intent of Section 4711 is to provide states with maximum flexibility, as well as to minimize HCFA's role in reviewing inpatient and long-term care state plan amendments involving payment rate changes. HCFA would consider the state to be in compliance with this provision if it elected to use a general administrative process similar to the Federal Administrative Procedures Act that satisfies the requirements for a public process in developing and inviting comment in Section 4711. This will allow states the flexibility to follow current state procedures. If a state's public process is not currently being applied to rate setting, or does not currently include a comment period, then the state would need to modify the process. (See Enclosure 2 for public process options.)

The repeal of the Boren amendment cannot be interpreted to be retroactively effective; the Boren amendment still applies to payment for items and services furnished before October 1, 1997. Thus, inpatient hospital and long-term state plan amendments that are currently pending approval by HCFA, including

those where Boren requirement questions are the only outstanding issues, need to have these issues resolved before amendment can be approved. However, we recognize that the intent in repealing the Boren amendment was to reduce HCFA's role in the institutional payment rate setting process and to increase state latitude in this area. In light of the less restrictive requirements now in place, HCFA is committed to working with states to expedite resolution of outstanding Boren issues in existing pending amendments.

States that are not proposing changes in their payment methods and standards, or changes in rates for items and services furnished on or after October 1, 1997, need not immediately implement a BBA public process. States need only publish proposed rates, methodologies, and justification prior to the proposed effective date of any changes in payment rates or payment methodologies. In other words, states are not required to subject their existing rates to a public process to the extent that those existing rates were validly determined in accordance with legal standards in effect prior to October 1, 1997. In the event changes are already underway, states are to submit the preprint page (or comparable language inserted elsewhere in the hospital and long-term care payment sections of the plan) with the next proposed amendment. (See Enclosures 3 and 4 for preprint pages.) We envision a streamlined Federal review process due to the fact that state plan amendments previously submitted under the Boren requirements were subjected to more rigorous statutory standard both in terms of Federal review of their substance and the review of the process itself.

Chapter 98-46, Laws of Florida.

55. The 1998 Florida Legislature passed legislation directing Respondent to make changes to the ICF/DD Methodology.

The directive was contained in Chapter 98-46, Laws of Florida, Sections 13 and 40 of which provided as follows:

> Section 13. In order to implement Specific Appropriation 243 of the 1998-1999 General Appropriations Act, subsection (22) is added to section 409.908, Florida Statutes, to read:
>
> 409.908 Reimbursement of Medicaid providers.-Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.
>
> (22) The agency is directed to implement changes in the Medicaid reimbursement methodology, as soon as feasible, to contain the growth in expenditures in facilities formerly known as ICF/DD facilities.[24] In light of the repeal of the federal Boren Amendment, the agency shall consider, but is not limited to, the following changes in methodology:

(a) Reduction in the target rate of inflation.

(b) Reduction in the calculation of incentive payments.

(c) Ceiling limitations by component of reimbursement.

(d) Elimination of rebase provisions.

(e) Elimination of component interim rate provisions.

(f) Separate reimbursement plans for facilities that are government operated versus facilities that are privately owned.

The agency may contract with an independent consultant in considering any changes to the reimbursement methodology for these facilities. This subsection is repealed on July 1, 1999.

Section 40. This act shall take effect July 1, 1998, or in the event this act fails to become a law until after that date, it shall operate retroactively thereto.

56. Chapter 98-46, Laws of Florida, became a law without the Governor's approval on April 30, 1998.

Respondent's Response to Chapter 98-46, Laws of Florida Becoming a Law

57. The task of taking the necessary steps to comply with the legislative directive contained in Chapter 98-46, Laws of Florida, was the responsibility of John Owens, a Regulatory Analyst Supervisor with Respondent, whose job duties include "overseeing the various reimbursement plans for Medicaid and their application." Mr. Owens' training is primarily in accounting and finance, not health care.

58. Mr. Owens acted in consultation with his immediate supervisor, Carlton Snipes, as well as the Director of Respondent's Division of Health Purchasing and agency counsel. He did not employ any independent consultants to assist him.

59. After formulating revisions to the ICF/DD Methodology that he preliminarily determined should be made in light of legislative mandate in Section 13 of Chapter 98-46, Laws of Florida, Mr. Owens had published in the August 14, 1998, edition of the Florida Administrative Weekly the following notices of proposed rule development:

> AGENCY FOR HEALTH CARE ADMINISTRATION
> Medicaid
>
> RULE CHAPTER TITLE: Reimbursement of Providers
>
> RULE CHAPTER NO.: 59G-6
>
> RULE TITLE: Payment Methodology for ICF/MR-DD Services in Publicly Owned and Publicly Operated Facilities.
>
> RULE NO.: 59G-6.040
>
> PURPOSE AND EFFECT: The purpose of the proposed amendment is to revise the current reimbursement plan and methodology to apply only to ICF/MR-DD facilities which are publicly owned and publicly operated. The effect of the proposed amendment is to provide specific policies for the administration and calculation of payments for this program.
>
> SUBJECT AREA TO BE ADDRESSED: The proposed amendment to rule 59G-6.040 incorporates revisions to the plan so that the plan only applies to ICF/MR-DD facilities which are publicly owned and publicly operated. In addition, the revisions to the plan eliminate

automatic requirements for rebasing and eliminates the target rate inflation limitation.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.908 FS.

IF REQUESTED AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE REVELOPMENT WORKSHOP WILL BE ADVERTISED AT A LATER DATE

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, P. O. Box 12400, Tallahassee, Florida 32317-2400

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-6.040 Payment Methodology for ICF/MR-DD Services in Publicly Owned and Publicly Operated Facilities.

Reimbursement to participating ICF/MR-DD facilities for services provided shall be in accord with the Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities, Version VII, ~~Version VI, November 15, 1994~~, incorporated herein by reference. A copy of the Plan as revised may be obtained by writing to John A. Owens, Medicaid Reimbursement, Agency for Health Care Administration, P.O. Box 12400, Tallahassee, Florida 32399-0700.

Specific Authority 409.919 FS. Law Implemented 409.908 FS. History--New 7-1-85, Amended 2-25-86, 10-1-89, 8-14-90, 12-26-90, 9-17-91, 1-27-94, 12-15-94 _____

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid

RULE CHAPTER TITLE: Reimbursement of Providers

RULE CHAPTER NO.: 59G-6

RULE TITLE: Payment Methodology for ICF/MR-DD Services in Facilities Not Publicly Owned and Publicly Operated.

RULE NO.: 59G-6.045

PURPOSE AND EFFECT: The purpose of the proposed new rule is to establish a reimbursement plan and methodology for ICF/MR-DD facilities that are not publicly owned and publicly operated. The effect of the proposed rule is to provide specific policies for administration and calculation of payments for this program.

SUBJECT AREA TO BE ADDRESSED: The proposed new rule 59G-6.045 establishes a separate reimbursement methodology for ICF/MR-DD facilities that are not publicly owned and publicly operated while reducing the target rate inflation limitation and eliminating the automatic requirements for rebasing.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.902, 409.908 FS.

IF REQUESTED AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE REVELOPMENT WORKSHOP WILL BE ADVERTISED AT A LATER DATE

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, P. O. Box 12400, Tallahassee, Florida 32317-2400

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-6.045 Payment Methodology for ICF/MR-DD Services in Facilities Not Publicly Owned and Publicly Operated.

Reimbursement to participating facilities for services provided shall be in accord with the Florida Title XIX ICF/MR-DD Reimbursement Plan for Facilities Not Publicly Owned and Publicly Operated, Version I, incorporated herein by reference. A copy of the Plan may

be obtained by writing to John A. Owens, Medicaid Reimbursement, Agency for Health Care Administration, P.O. Box 12400, Tallahassee, Florida 32399-0700.

Specific Authority 409.919 FS. Law Implemented 409.908 FS. History-New______

60. Notice of Respondent's intent to adopt the proposed amendment of Rule 59G-6.040, Florida Administrative Code, and proposed new Rule 59G-6.045, Florida Administrative Code (as set forth in the August 14, 1998, edition of the Florida Administrative Weekly, which will be referred to hereinafter as the "Proposed Rules"), was published in the August 21, 1998, edition of the Florida Administrative Weekly. These notices provided as follows:

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid

RULE TITLE: Payment Methodology for ICF/MR-DD Services in Publicly Owned and Publicly Operated Facilities.

RULE NO.: 59G-6.040

PURPOSE AND EFFECT: The purpose of the proposed amendment is to revise the current reimbursement plan and methodology to apply only to ICF/MR-DD facilities which are publicly owned and publicly operated. The effect of the proposed amendment is to provide specific policies for the administration and calculation of payments for this program.

SUMMARY: The proposed amendment to rule 59G-6.040 incorporates revisions to the plan so that the plan only applies to ICF/MR-DD facilities which are publicly owned and publicly operated. In addition, the revisions to the plan eliminate automatic

requirements for rebasing and eliminates the target rate inflation limitation.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: A statement of estimated regulatory cost has not been prepared. Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.908 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 10:00 A.M., September 14, 1998

PLACE: Conference Room I, 2728 Fort Knox Boulevard, Building 3, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, P. O. Box 12400, Tallahassee, Florida 32317-2400

THE FULL TEXT OF THE PROPOSED RULE IS:

59G-6.040 Payment Methodology for ICF/MR-DD Services in Publicly Owned and Publicly Operated Facilities..

Reimbursement to participating ICF/MR-DD facilities for services provided shall be in accord with the Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities, Version VII, ~~Version VI, November 15, 1994~~, incorporated herein by reference. A copy of the Plan as revised may be obtained by writing to John A. Owens, Medicaid Reimbursement, Agency for Health Care Administration, P.O. Box 12400, Tallahassee, Florida 32399-0700.

Specific Authority 409.919 FS. Law Implemented 409.908 FS. History--New 7-1-85, Amended 2-25-86, 10-1-89, 8-14-90, 12-26-90, 9-17-91, 1-27-94, 12-15-94 _____

NAME OF PERSON ORIGINATING PROPOSED RULE: Mr. John Owens

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Mr. Douglas M. Cook
DATE PROPOSED RULE APPROVED: August 12, 1998
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 14, 1998

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid

RULE TITLE: Payment Methodology for ICF/MR-DD Services in Facilities Not Publicly Owned and Publicly Operated.

RULE NO.: 59G-6.045

PURPOSE AND EFFECT: The purpose of the proposed new rule is to establish a reimbursement plan and methodology for ICF/MR-DD facilities that are not publicly owned and publicly operated (Facilities formerly known as ICF/DD Facilities). The effect of the proposed rule is to provide specific policies for administration and calculation of payments for this program.

SUMMARY: The proposed new rule 59G-6.045 establishes a separate reimbursement methodology for facilities that are not publicly owned and publicly operated (Facilities formerly known as ICF/DD Facilities) while reducing the target rate inflation limitation and eliminating the automatic requirements for rebasing.

SUMMARY OF STATEMENT OF REGULATORY COST: A statement of estimated regulatory cost has not been prepared. Any person who wishes to provide information regarding a statement of estimated regulatory cost, or provide a proposal for lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.902, 409.908 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 10:00 A.M., September 14, 1998

PLACE: Conference Room I, 2728 Fort Knox Boulevard, Building 3, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, P. O. Box 12400, Tallahassee, Florida 32317-2400

THE FULL TEXT OF THE PROPOSED RULE IS:

59G-6.045 Payment Methodology for Services in Facilities Not Publicly Owned and Publicly Operated (Facilities Formerly Known as ICF/DD Facilities).

Reimbursement to participating facilities for services provided shall be in accord with the Florida Title XIX Reimbursement Plan for Facilities Not Publicly Owned and Publicly Operated, (Facilities Formerly Known as ICF/DD Facilities), Version I, incorporated herein by reference. A copy of the Plan may be obtained by writing to John A. Owens, Medicaid Reimbursement, Agency for Health Care Administration, P.O. Box 12400, Tallahassee, Florida 32399-0700.

Specific Authority 409.919 FS. Law Implemented 409.908 FS. History-New

61. The "summaries" in these notices of proposed rulemaking accurately describe the changes to the ICF/DD Methodology that would occur if Respondent engaged in such rulemaking. Publicly operated ICF/DDs would be reimbursed pursuant to a modified

version of the plan that is currently used to reimburse both publicly and privately-operated ICF/DDs (Proposed Public Plan), and private ICF/DD providers would be reimbursed pursuant to a different modified version of the existing plan (Proposed Private Plan), less generous than both the existing plan and Proposed Public Plan.

62. The Proposed Private Plan would reduce the "target rate of inflation" from 1.786 (under the existing plan) to 1.4 (times the average cost increase in the "Florida ICF/MR-DD Cost Inflation Index").

63. Under the Proposed Public Plan, reimbursement would not be limited by any "target rate of inflation." As a result, costs of a state-operated ICF/DD (paid from general revenues appropriated by the Florida Legislature) that would not be reimbursable under the existing plan because they would be in excess of the ceiling established by application of the "target rate of inflation" feature of the plan would be eligible, under the Proposed Public Plan, for Medicaid funding, and, consequently, the state would be able to obtain additional federal financial participation (FFP) dollars, and ease its financial burden.

64. Neither the Proposed Public Plan, nor the Proposed Private Plan, contains the "rebasing" provisions found in the existing plan; however, the absence of these provisions is significant only insofar as the Proposed Private Plan is

concerned inasmuch as the Proposed Public Plan, as noted above, unlike the Proposed Private Plan, lacks any "target rate of inflation" feature which would place a cap on increases in reimbursable costs from one cost-reporting period to the next.

65. Included in both the Proposed Public Plan and the Proposed Private Plan are the "interim rate" provisions, as well as the "Payment Assurance" and "Provider Participation" sections, found in the existing plan.

66. Mr. Owens estimated (after notice of the Proposed Rules was published) that, under the Proposed Private Plan, over a one-year period,[25] private ICF/DD providers would receive approximately $650,000.00 to $670,000.00 less in Medicaid payments than under the existing plan.[26]

67. Petitioner (which operates a fifth to a fourth of all private ICF/DD beds in Florida) has estimated that, in the next five years, it would receive $5 million less in Medicaid payments under the Proposed Private Plan than under the existing plan, and it questions whether, under such circumstances, it would be able to continue to provide ICF/DD services in Florida.

Additional Notice Published in Florida Administrative Weekly

68. As part of an effort to comply with the procedural requirements of 42 U.S.C. 1396a(a)(13) (that had replaced the provisions of the Boren Amendment), Respondent had published the following additional notice in the August 21, 1998, edition of the Florida Administrative Weekly:

The Florida Agency for Health Care Administration (the Agency), Bureau of Medicaid Program Analysis provides the following public notice regarding reimbursement for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICF-MR/DD) facilities.

PURPOSE: To comply with federal public notice requirements in Section 1902(a)(13)(A) of the Social Security Act in changing reimbursement for intermediate care facilities for the mentally retarded, the Agency is publishing the proposed rates, the methodologies underlying the establishment of such rates, and justification for the proposed rates. The Agency is in the process of amending its ICF-MR/DD reimbursement plan with the Health Care Financing Administration (HCFA). The proposed amendment will revise the current plan to only apply to publicly owned and publicly operated ICF-MR/DD facilities and will create a new reimbursement plan for ICF-MR/DD facilities that are not publicly owned and publicly operated (Facilities formerly known under Florida State law as ICF/DD Facilities).

PROPOSED RATES: The proposed rates, effective October 1, 1998, for publicly owned and publicly operated ICF-MR/DD facilities will be rates resulting from the current methodology used to calculate rates, except that the target limitation factor and the requirement for automatic rebasing will be eliminated. The proposed rates, effective October 1, 1998, for ICF-MR/DD facilities that are not publicly owned and publicly operated (Facilities formerly known under Florida State law as ICF/DD Facilities) will be rates resulting from the current methodology used to calculate rates, except that the target limitation factor will be reduced from 1.786 to 1.4 and the requirement for automatic rebasing will be eliminated.

MEHTODOLOGIES: The methodologies underlying the establishment of the proposed rates for ICF-MR/DD facilities that are publicly owned

and operated are based on the methodologies currently used for calculating rates, except that the target limitation factor and the requirement for automatic rebasing will be eliminated. The methodologies underlying the establishment of the proposed rates for ICF-MR/DD facilities that are not publicly owned and operated (Facilities formerly known under Florida State law as ICF/DD Facilities) are based upon the current methodology used to calculate rates, except that the target limitation factor will be reduced from 1.786 to 1.4 and the requirement for automatic rebasing will be eliminated.

JUSTIFICATION: The justification for the proposed rates is based on the legislative directive provided in Section 13, of House Bill 4205 (Implementing Bill for the 1998-1999 General Appropriations Act.) This section directs the Agency to implement changes in the Medicaid reimbursement methodology, as soon as feasible, to contain growth in expenditures in facilities formerly known as ICF/DD facilities. The Agency is proposing the above rates and changes in methodology, effective October 1, 1998, to comply with the legislative direction. Providers, beneficiaries and their representatives, and other concerned State residents may provide written comment on the proposed rates, methodologies and justification underlying the establishment of such rates. Written comments may be submitted to: John Owens, Agency for Health Care Administration, Post Office Box 12400, Tallahassee, Florida 32317-2400. Written comments should be submitted no later than September 10, 1998. Copies of the reimbursement plans incorporating the above changes may be obtained by contacting John Owens, Medicaid Cost Reimbursement Section, at the address noted above.

Petitioner's Challenge

69. On September 9, 1998, Petitioner filed with the Division a petition challenging the Proposed Rules pursuant to Chapter 120, Florida Statutes.

Petitioner's Proposal for Lower Cost Regulatory Alternative

70. On that same day, September 9, 1998, Petitioner filed with Respondent a Proposal for Lower Cost Regulatory Alternative, which provided as follows:

> SUNRISE COMMUNITY, INC. submits the following Proposal for Lower Cost Regulatory Alternative in regard to Agency for Health Care Administration proposed rules entitled "Payment Methodology for ICF/MR-DD Services [in] Publicly Owned and Publicly Operated Facilities," Rule No. 59G-6.040, and "Payment Methodology for Services and Facilities Not Publicly Owned and Publicly Operated (Facilities Formerly Known as ICF/DD Facilities)," Rule No. 59G-6.045, published in the Florida Administrative . . . Weekly on August 21, 1998, and states as follows:
>
> 1. The Agency for Health Care Administration and governing Medicaid reimbursement principles already require that no costs may be reimbursed unless they are both reasonable and necessary.
>
> 2. A significant burden is imposed on the regulated persons, as well as a significant burden on the Agency for Health Care Administration, in the above-proposed rules based on the complex procedures for rate setting.
>
> 3. Since the ICF/MR-DD program already requires efficiency by only permitting reimbursement of reasonable and necessary costs and since the Agency must pay sufficient rates to insure that there is adequate quality of care and adequate access to availability of services and must otherwise comply with federal Medicaid provisions, Sunrise respectfully submits that

a lower cost regulatory alternative exists, to wit: a payment of all reasonable and necessary costs together with continuation of the current auditing by the Agency for Health Care Administration to insure that no costs are reimbursed unless they are reasonable and necessary.

4. Moreover, a plan such as that proposed herein has been evaluated by the Agency and proposed for adoption for publicly owned and operated facilities.

5. Sunrise Community, Inc. is located a 9040 Sunset Drive, Suite #70-A, Miami, Florida 33173 and is an operator of large and small ICF/MR-DD facilities, both publicly owned and privately owned, and has a substantial interest in these rules.

71. In response to Petitioner's Proposal for Lower Cost Regulatory Alternative, Respondent issued the following Statement of Estimated Regulatory Costs:

Detailed below is the Statement of Estimated Regulatory Costs prepared by the Agency for Health Care Administration ("Agency") as it pertains to the amendment of Rule 59G-6.040, F.A.C., Payment Methodology for ICF/MR-DD Services in Publicly Owned and Operated Facilities, and the adoption of Rule 59G-6.045, F.A.C., Payment Methodology for Services in Facilities Not Publicly Owned and Publicly Operated (Facilities Formerly Known As ICF/DD Facilities).

The amendment to Rule 59G-6.040 will effect twenty-one (21) providers of ICF/DD services. The adoption of Rule 59G-6.045 will effect ninety-one (91) facilities formerly known as ICF/DD facilities. Entities affected by these rules operate State ICF/DD facilities and facilities formerly known as ICF/DD facilities where they provide ICF/DD services to residents living in their respective facilities. These entities receive reimbursement from the Florida Medicaid Program for providing these services.

It is estimated that there will be no cost to the Agency or any other state and local government entities in implementing the amendment to Rule 59G-6.040 and the adoption of Rule 59G-6.045. It is anticipated that implementing these rules will provide savings in state general revenues.

It is anticipated that there will be no transactional costs incurred by the entities required to comply with these rules. The referenced rules detail the reimbursement methodology employed by the Florida Medicaid Program to reimburse facilities that provide ICF/DD services to Medicaid recipients. The amendment to Rule 59G-6.040 and adoption of Rule 59G-6.045 do not require any of the affected entities to incur new costs for purposes of complying with the requirements of the rules nor do they require any additional costs to be incurred for reporting purposes.

As noted above Rules 59G-6.040 and 59G-6.045 detail the reimbursement methodology used by the Florida Medicaid Program to reimburse facilities that provide ICF/DD services to Medicaid recipients. The proposed amendment to Rule 59G-6.040 and the adoption of Rule 59G-6.045 are being made to establish the level of reimbursement that will be paid by the Medicaid program for facilities providing ICF/DD services. The implementation of these rules will not require any additional expenditures or place new regulatory requirements on small businesses as defined by s. 288.703. These rules will have no impact on small counties or small cities, as none of the facilities affected by the rules are counties or cities.

The proposed changes to Rules 59G-6.040 and 59G-6.045 are being made at the direction of the Florida Legislature. House Bill 4205, Section 13 directed the Agency to implement changes in the Medicaid reimbursement methodology to contain the growth in expenditures in facilities formerly known as ICF/DD facilities. It is the Agency's intent

to comply with the direction of the Florida Legislature by implementing these changes in rule.

In response to the publication of the Notice of Proposed Rule for the amendment of Rule 59G-6.040 and the adoption of Rule 59G-6.045 in the Florida Administrative Weekly, August 21, 1998, Volume 24, Number 34, a Proposal for Lower Cost Regulatory Alternative was submitted to the Agency. The proposed lower cost regulatory alternative offered is that, "a payment of all reasonable and necessary costs together with continuation of the current auditing by the Agency for Health Care Administration to insure that no costs are reimbursed unless they are reasonable and necessary.

The Agency does not accept the proposed lower cost regulatory alternative submitted. To accept the proposed alternative would be contrary to established Medicaid reimbursement policies and the intent of the Florida Legislature in directing the Agency to make the proposed changes in rule. Both of the proposed rules require facilities being reimbursed by Medicaid for ICF/DD services to report costs in accordance with the appropriate reimbursement plan. To determine the level of reimbursement under Rule 59G-6.045, a target rate of inflation for cost increases is used as a measure of efficient operation. To eliminate the use of a target rate of inflation would void the cost containment features used by the Medicaid program to control expenditures and be opposite the directive given to the Agency by the Florida Legislature.

CONCLUSIONS OF LAW

72. In the instant case, Petitioner is challenging the Respondent's Proposed Rules pursuant to Section 120.56, Florida Statutes, which provides, in pertinent part, as follows:

120.56 Challenges to rules.-

(1) GENERAL PROCEDURES FOR CHALLENGING THE VALIDITY OF A RULE OR A PROPOSED RULE.-

(a) Any person substantially affected by . . . a proposed rule may seek an administrative determination of the invalidity of the rule on the ground that the rule is an invalid exercise of delegated legislative authority.

(b) The petition seeking an administrative determination must state with particularity the provisions alleged to be invalid with sufficient explanation of the facts or grounds for the alleged invalidity and facts sufficient to show that the person challenging a rule is substantially affected by it, or that the person challenging a proposed rule would be substantially affected by it.

(c) The petition shall be filed with the division which shall, immediately upon filing, forward copies to the agency whose rule is challenged, the Department of State, and the committee. Within 10 days after receiving the petition, the division director shall, if the petition complies with the requirements of paragraph (b), assign an administrative law judge who shall conduct a hearing within 30 days thereafter, unless the petition is withdrawn or a continuance is granted by agreement of the parties or for good cause shown. . . . The failure of an agency to follow the applicable rulemaking procedures or requirements set forth in this chapter shall be presumed to be material; however, the agency may rebut this presumption by showing that the substantial interests of the petitioner and the fairness of the proceedings have not been impaired.

(d) Within 30 days after the hearing, the administrative law judge shall render a decision and state the reasons therefor in writing. The division shall forthwith transmit copies of the administrative law judge's decision to the agency, the Department of State, and the committee.

(e) Hearings held under this section shall be conducted in the same manner as provided by ss. 120.569 and 120.57, except that the administrative law judge's order shall be final agency action. The petitioner and the agency whose rule is challenged shall be adverse parties. Other substantially affected persons may join the proceedings as intervenors on appropriate terms which shall not unduly delay the proceedings. Failure to proceed under this section shall not constitute failure to exhaust administrative remedies.

(2) CHALLENGING PROPOSED RULES; SPECIAL PROVISIONS.-

(a) Any substantially affected person may seek an administrative determination of the invalidity of any proposed rule by filing a petition seeking such a determination with the division within 21 days after the date of publication of the notice required by s. 120.54(3)(a), within 10 days after the final public hearing is held on the proposed rule as provided by s. 120.54(3)(c), within 20 days after the preparation of a statement of estimated regulatory costs required pursuant to s. 120.541, if applicable, or within 20 days after the date of publication of the notice required by s. 120.54(3)(d). The petition shall state with particularity the objections to the proposed rule and the reasons that the proposed rule is an invalid exercise of delegated legislative authority. The agency then has the burden to prove that the proposed rule is not an invalid exercise of delegated legislative authority as to the objections raised. Any person who is substantially affected by a change in the proposed rule may seek a determination of the validity of such change. . . .

(b) The administrative law judge may declare the proposed rule wholly or partly invalid. The proposed rule or provision of a proposed rule declared invalid shall be withdrawn by the adopting agency and shall not be adopted. No rule shall be filed for adoption until 28 days after the notice required by s.

> 120.54(3)(a), until 21 days after the notice required by s. 120.54(3)(d), until 14 days after the public hearing, until 21 days after preparation of a statement of estimated regulatory costs required pursuant to s. 120.541, or until the administrative law judge has rendered a decision, whichever applies. However, the agency may proceed with all other steps in the rulemaking process, including the holding of a factfinding hearing. In the event part of a proposed rule is declared invalid, the adopting agency may, in its sole discretion, withdraw the proposed rule in its entirety. The agency whose proposed rule has been declared invalid in whole or part shall give notice of the decision in the first available issue of the Florida Administrative Weekly.
>
> (c) When any substantially affected person seeks determination of the invalidity of a proposed rule pursuant to this section, the proposed rule is not presumed to be valid or invalid. . . .

73. "A party challenging a proposed rule [pursuant to Section 120.56, Florida Statutes] has the burden of establishing a factual basis for the objections to the rule, and then the agency has the ultimate burden of persuasion to show that the proposed rule is a valid exercise of delegated legislative authority." Agency for Health Care Administration, Board of Clinical Laboratory Personnel v. Florida Coalition of Professional Laboratory Organizations, Inc., 1998 WL 558983 (Fla. 1st DCA September 4, 1998); St. Johns River Water Management District v. Consolidated Tomoka Land Co., 717 So. 2d 72, 76 (Fla. 1st DCA 1998).

74. A proposed rule may be challenged pursuant to Section 120.56, Florida Statutes, only on the ground that it is an

"invalid exercise of delegated legislative authority," as defined in Section 120.52(8), Florida Statutes,[27] which provides as follows:

> (8) "Invalid exercise of delegated legislative authority" means action which 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,[28] fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency;
>
> (e) The rule is arbitrary or capricious;[29]
>
> (f) The rule is not supported by competent substantial evidence; or
>
> (g) 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, interpret, or make specific the particular 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, 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 the particular powers and duties conferred by the same statute.[30]

The administrative law judge assigned to hear the challenge may declare the proposed rule invalid only if one (or more) of the "seven circumstances" enumerated in subsections (8)(a) through (f) of Section 120.52, Florida Statutes, are found to exist. See St. Johns River Water Management District v. Consolidated Tomoka Land Co., 717 So. 2d 72, 77 (Fla. 1st DCA 1998). To base a finding of invalidity on circumstances not specifically mentioned in Section 120.52(8), Florida Statutes, would be an impermissible extension of the administrative law judge's authority beyond the boundaries established by the Legislature. See Moonlit Waters Apartments v. Cauley, 666 So. 2d 898, 900 (Fla. 1996)("Under the principle of statutory construction, expressio unius est exclusio alterius, the mention of one thing implies the exclusion of another."); City of Cape Coral v. GAC Utilities, Inc., of Florida, 281 So. 2d 493, 495-96 (Fla. 1973)("All administrative bodies created by the Legislature are not constitutional bodies, but, rather, simply mere creatures of statute. This, of course, includes the Public Service Commission. . . . As such, the Commission's powers, duties and authority are those and only

those that are conferred expressly or impliedly by statute of the State. . . . Any reasonable doubt as to the lawful existence of a particular power that is being exercised by the Commission must be resolved against the exercise thereof, . . . and the further exercise of the power should be arrested."); Coastal Petroleum Company v. Department of Environmental Protection, 649 So. 2d 930 (Fla. 1st DCA 1995)("Relying upon the well established principle that the powers of administrative agencies are measured and limited by the statutes or acts in which such powers are expressly granted or implicitly conferred, . . . the appellants correctly argue that the final order must be reversed because the department acted without authority and contrary to legislative intent when it required security in excess of the annual fund fee."); Sun Coast International, Inc. v. Department of Business Regulation, 596 So. 2d 1118, 1121 (Fla. 1st DCA 1991)("[A] legislative direction as to how a thing shall be done is, in effect, a prohibition against its being done in any other way."); Schiffman v. Department of Professional Regulation, Board of Pharmacy, 581 So. 2d 1375, 1379 (Fla. 1st DCA 1991) ("An administrative agency has only the authority that the legislature has conferred it by statute."); Department of Environmental Regulation v. Puckett Oil, 577 So. 2d 988, 991 (Fla. 1st DCA 1991)("We are of the view that if it was DOAH's intent in adopting rule 22I-6.035(5)(a) to establish a jurisdictional time limitation upon the filing of an agency's responsive pleading to

a petition for fees and costs, DOAH has acted in excess of any express or reasonably implied delegated legislative authority. It is well recognized that the powers of administrative agencies are measured and limited by the statutes or acts in which such powers are expressly granted or implicitly conferred.").

75. In the instant case, Petitioner objects to the Proposed Rules on various grounds. Among its arguments is that the Proposed Rules "constitute[] an invalid exercise of delegated legislative authority as [they] go[] beyond the powers, functions and duties delegated by the legislature" and are arbitrary and capricious.

76. "[T]he review standards for assessing the [substantive] validity of proposed rules [were] drastically altered by the 1996 amendments to Florida's Administrative Procedure Act. . . . [T]he 1996 [L]egislature intended, through its enactment of sections 120.52(8) and 120.536(1),[31] Florida Statutes . . . to overrule earlier Florida decisions to the extent that they had held a rule was a valid exercise of delegated legislative authority if it was reasonably related to the enabling statute and not arbitrary or capricious." Department of Business and Professional Regulation v. Calder Race Course, Inc., 1998 WL 422515 (Fla. 1st DCA July 29, 1998).

77. Under the current statutory framework, "the proper test to determine whether a rule is a valid exercise of delegated authority is a functional test based on the nature of the power

or duty at issue and not the level of detail in the language of the applicable statute. The question is whether the rule falls within the range of powers the Legislature has granted to the agency for the purpose of enforcing or implementing the statutes within its jurisdiction. A rule is a valid exercise of delegated legislative authority if it regulates a matter directly within the class of powers and duties identified in the statute to be implemented. This approach meets the legislative goal of restricting the agencies' authority to promulgate rules, and, at the same time, ensures that the agencies will have the authority to perform the essential functions assigned to them by the Legislature." St. Johns River Water Management District v. Consolidated Tomoka Land Co., 717 So. 2d 72, 80-81 (Fla. 1st DCA 1998).

78. Applying these principles to the instant case, it is evident that Respondent has the statutory authority to adopt the Proposed Rules. In subsection (22) of Section 409.908, Florida Statutes, the statutory provision which Respondent seeks to implement by adopting the Proposed Rules, the Florida Legislature directs Respondent "to contain the growth in expenditures in facilities formerly known as ICF/DD facilities"[32] by "implement[ing] changes in the Medicaid methodology," such as "[r]eduction in the target rate of inflation"; "[e]limination of rebase provisions"; and "[s]eparate reimbursement plans for facilities that are government operated versus facilities that

are privately owned."[33] This is precisely what Respondent proposes to do by adopting the Proposed Rules. Taking such proposed action, therefore, would not be arbitrary and capricious, but rather would clearly be "within the range of powers the Legislature has granted to [Respondent] for the purpose of enforcing or implementing the statutes within its jurisdiction."

79. Petitioner makes the argument that Respondent is without the authority to adopt the Proposed Rules because such action would be in violation of federal Medicaid law and the Americans with Disabilities Act, as well as a "Federal District Court Order and Federal District Court Injunction" (which were based on principles of federal law[34]), and therefore would be arbitrary and capricious and contrary to the mandate contained in the prefatory language of Section 409.908, Florida Statutes, that Respondent "reimburse Medicaid providers, in accordance with . . . federal law." This argument overlooks the clear (and most recent) expression of legislative intent in subsection (22) of Section 409.908, Florida Statutes, which specifically addresses the reimbursement of ICF/DD providers.[35] Reading subsection (22) (with its reference to the "repeal of the Boren Amendment") together with the prefatory language of Section 409.908, Florida Statutes, it is apparent that, when it enacted Chapter 98-46, Laws of Florida, the Legislature was of the view that, "in light of the repeal of the Boren Amendment," federal

law did not prohibit Respondent from making the changes to the existing ICF/DD Methodology described in subsection (22).[36] Otherwise, it would not have authorized Respondent to make these changes. To accept Petitioner's argument that (contrary to the view taken by the Legislature) the changes that Respondent proposes to make to the existing ICF/DD Methodology are not "in accordance with . . . federal law" and to invalidate the Proposed Rules on the basis of such conflict would render the Legislature's addition of subsection (22) to Section 409.908, Florida Statutes, which specifically authorizes Respondent to make such changes, meaningless and without force and effect. This the undersigned cannot do.[37] See Palm Harbor Special Fire Control District v. Kelly, 516 So. 2d 249 (Fla. 1987)("[I]t is axiomatic that an administrative agency has no power to declare a statute void or otherwise unenforceable."); Secretary of State v. Milligan, 704 So. 2d 152, 157 (Fla. 1st DCA 1997)("[A]n administrative agency has no power to declare a statute void or otherwise unenforceable and there is no obligation to defer to an agency interpretation that results in a statute being voided by administrative fiat."); Holmes v. City of West Palm Beach, 627 So. 2d 52 (Fla. 4th DCA 1993)("[A]ppellee correctly contends that because it is an administrative agency, rather than a court, it cannot circumvent unambiguous statutory provisions in the interest of fairness and due process considerations. . . . It

lacks the power to declare a statute void or otherwise unenforceable.").[38]

80. Petitioner also contends that the "Proposed Rules are vague or fail to establish standards for Agency decisions and/or vest unbridled discretion in the Agency," in violation of Section 120.52(8)(d), Florida Statutes, inasmuch as the "[P]roposed rules as stated fail to identify the methodology to be used for reimbursement, fail to refer to the applicable reimbursement plan, and, in short, require [Petitioner] and the general public to necessarily guess the rules' meaning." It is true that neither the Proposed Public Plan, nor the Proposed Private Plan, is set out in full in the Proposed Rules. The Proposed Rules, however, do refer to the Proposed Public Plan and Proposed Private Plan and incorporate them by reference, as permitted by Section 120.54(1)(i), Florida Statutes, which provides, in pertinent part, as follows:

> A rule may incorporate material by reference but only as the material exists on the date the rule is adopted.

See also Section 409.908, Florida Statutes ("[T]he agency shall reimburse Medicaid providers . . . according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein.").[39] The Proposed Public Plan and Proposed Private Plan, therefore, are part of the Proposed Rules. These plans set forth in detail the methodologies that would be used by Respondent to determine the

amount of Medicaid payments ICF/DD providers would receive if the Proposed Rules were adopted. The plans are not vague and would not vest Respondent with unbridled discretion. They contain adequate standards to guide Respondent in making its Medicaid reimbursement decisions. Accordingly, adopting the Proposed Rules would not constitute an "invalid exercise of delegated legislative authority," within the meaning of Section 120.52(8)(d), Florida Statutes.

81. Petitioner further challenges the Proposed Rules on procedural grounds. More specifically, Petitioner argues that Respondent has failed to comply with applicable notice requirements in developing the Proposed Rules. As noted above, adopting a proposed rule would be an "invalid exercise of legislatively delegated authority," as defined in Section 120.52(8)(a), Florida Statutes, if "[t]he agency has materially[40] failed to follow the applicable rulemaking procedures or requirements set forth in [Chapter 120, Florida Statutes]." Among the procedural rulemaking requirements set forth in Chapter 120, which, if not followed, may result in a finding that there would be "an invalid exercise of delegated legislative authority," as contemplated by subsection (8)(a) of Section 120.52, Florida Statutes, are the notice requirements found in subsection (3)(a) of Section 120.54, Florida Statutes, which provides, in pertinent part, as follows:

> (3) ADOPTION PROCEDURES.-

(a) Notices.–

1. Prior to the adoption, amendment, or repeal of any rule other than an emergency rule, an agency, upon approval of the agency head, shall give notice of its intended action, setting forth a short, plain explanation of the purpose and effect of the proposed action; the full text of the proposed rule or amendment and a summary thereof; a reference to the specific rulemaking authority pursuant to which the rule is adopted; and a reference to the section or subsection of the Florida Statutes or the Laws of Florida being implemented, interpreted, or made specific. The notice shall include a summary of the agency's statement of the estimated regulatory costs, if one has been prepared, based on the factors set forth in s. 120.541(2), and a statement that any person who wishes to provide the agency with information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative as provided by s. 120.541(1),[41] must do so in writing within 21 days after publication of the notice. The notice must state the procedure for requesting a public hearing on the proposed rule. Except when the intended action is the repeal of a rule, the notice shall include a reference both to the date on which and to the place where the notice of rule development that is required by subsection (2) appeared.

2. The notice shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action. The proposed rule shall be available for inspection and copying by the public at the time of the publication of notice.

3. The notice shall be mailed to all persons named in the proposed rule and to all persons who, at least 14 days prior to such mailing, have made requests of the agency for advance notice of its proceedings. The agency shall also give such notice as is prescribed by

> rule to those particular classes of persons to whom the intended action is directed. . . .

82. It appears that Respondent has complied with these notice requirements set forth in Chapter 120, Florida Statutes, to the extent applicable. Petitioner does not expressly contend otherwise. Rather, it argues that Petitioner has failed to comply with the notice requirements set forth in 42 USC Section 1396a(a)(13)(A) and 42 CFR Section 447.205(a); however, to the extent that these provisions of federal law may impose procedural requirements different from those prescribed in Chapter 120, Florida Statutes, Respondent's failure to comply with these federal requirements would not be an "invalid exercise of delegated legislative authority," within the meaning of Section 120.52(8)(a), Florida Statutes.[42] Only the failure to follow the applicable rulemaking procedures or requirements of Chapter 120, Florida Statutes, would constitute such an "invalid exercise of delegated legislative authority."

83. A review of the record in the instant case reveals that Petitioner has established that, in all material respects (both substantive and procedural), the Proposed Rules would not be "invalid exercises of delegated legislative authority," within the meaning of Section 120.52(8), Florida Statutes.

Accordingly, it is hereby ORDERED that Petitioner's petition challenging the Proposed Rules pursuant to 120.56, Florida Statutes, is dismissed.

DONE AND ORDERED this 4th day of January, 1999, in Tallahassee, Leon County, Florida.

STUART M. LERNER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of January, 1999.

ENDNOTES

[1] 42 USC Section 1396a(a)(13)(A) provides as follows:

> § 1396a. State plans for medical assistance
>
> (a) Contents
>
> A State plan for medical assistance must--
>
> (13) provide--
>
> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs."

[2] 42 CFR Section 447.205(a) provides as follows:

Section 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.

(a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) When notice is not required. Notice is not required if--

(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

(3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) Content of notice. The notice must--

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) Publication of notice. The notice must--

(1) Be published before the proposed effective date of the change; and

(2) Appear as a public announcement in one of the following publications;

(i) A State register similar to the FEDERAL REGISTER.

(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.

(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

[3] 42 USC Section 1396a(a)(30)(A) provides as follows:

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with

> efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;

[4] On December 14, 1998, Respondent filed a motion requesting an extension of time to file its supplemental proposed final order. By order issued December 15, 1998, the motion was granted, and the deadline for filing Respondent's supplemental proposed final order was extended to December 23, 1998.

[5] On December 22, 19998, Respondent filed a Motion to Strike portions of the Proposed Findings of Fact Petitioner had submitted. On that same day (December 22, 1998), the undersigned issued an Order in which he disposed of the motion by stating the following:

> To the extent that Respondent requests that these portions of Petitioner's Proposed Findings of Fact be stricken and not considered by the undersigned, the motion is hereby DENIED; however, the undersigned will take into consideration the arguments made in Respondent's motion in evaluating Petitioner's Proposed Findings of Fact.

[6] Previously, these facilities were referred to as "ICF/MRs."

[7] There are currently four state-owned and operated ICF/DDs, all of which are located in isolated, rural areas. Historically, these ICF/DDs have been more costly to operate than privately-run ICF/DDs.

[8] Petitioner has a very small number of "private pay" clients, but it does not provide them services in an ICF/DD setting.

[9] Presently, there are approximately 3600 residents of ICF/DDs in Florida. Approximately, 2200 of them are in privately-owned and/or operated ICF/DDs.

[10] Florida ranks next to last among the fifty states in terms of the amount it spends on its developmentally disabled citizens.

[11] The "purpose" of the rules in Chapter 59G, Florida Statutes,

is described in Rule 59G-1.001, Florida Administrative Code, as follows:

> The agency adopts these rules to comply with the requirements of Chapter 409, Florida Statutes. All rules in 59G, F.A.C., must be read in conjunction with the statutes, federal regulations, and all other rules and regulations pertaining to the Medicaid program.

[12] Studies conducted in or around 1989 reflected that inflation in Florida was higher than the national average.

[13] Perhaps the most significant of these differences (for purposes of Medicaid reimbursement) is that almost all of the residents of ICF/DDs are Medicaid recipients, whereas no more than 30 to 40% of nursing home residents are Medicaid recipients. Unlike ICF/DDs, nursing homes are able to compensate for lack of Medicaid underfunding by charging more for services they provide their non-Medicaid residents.

[14] In a footnote, Judge Nesbitt observed the following:

> HRS has an incentive program which allows providers whose actual costs are lower than targeted costs to keep some of the difference. However, because nearly all providers are losing substantial amounts of money, this incentive is rarely triggered.

[15] Judge Nesbitt commented in a footnote that "Florida providers lost $2 million in one recent six-month period."

[16] In a footnote, Judge Nesbitt added the following:

> For example, as of June, 1990, the plan permitted one of the Plaintiffs, Sunrise, to pay their "direct care staff" only $3.85/hour, at least 50% less than the state pays staff at its own ICF/MR facilities. As a result, Sunrise could not attract even minimally skilled individuals. The resulting high vacancy rate forced them to spend more money on training, advertising and recruitment, and the high turnover rate has lead to a significantly diminished standard of care for patients. Also, Sunrise was ultimately required to increase wages, and the accompanying increased costs resulted in

> substantial layoffs, again significantly impacting on the quality of care.

[17] In a footnote, Judge Nesbitt cited the following example of a provider experiencing "these consistent and substantial unreimbursed costs":

> For example, one Plaintiff, United Cerebral Palsy, has spent over $1 million of its own monies to pay for operating expenses arising from care for patients, thereby diverting funds urgently needed for capital improvements.

[18] In a footnote, the Court added that "[t]he failure to obey the requirements of this preliminary injunction may result in the imposition of any and all sanctions available to this Court."

[19] In this Final Order, the underlining of statutory and rule language denotes that this language was added by the Legislature or agency; deletions are denoted by strike throughs.

[20] Section 393.16, Florida Statutes, created the "Intermediate Care Facilities Trust Fund" for the purpose of granting loans to any "residential intermediate care facility for persons with developmental disabilities which is operated by a corporation for profit or nonprofit corporation, by a partnership, or by a sole proprietorship, which is operated, approved, or contracted under the authority of the [appropriate state agency]; and which houses no more than 15 persons with developmental disabilities."

[21] In a footnote, Judge Ferguson noted that these facilities were "[p]reviously described as intermediate care facilities for the mentally retarded (ICF/MRs)."

[22] 42 CFR Section 430.10 defines a "state plan" as follows:

> The State plan is a comprehensive written statement submitted by the [state Medicaid] agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department [of Health and Human Services]. The state plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

[23] State Medicaid plans and plan amendments must be submitted to the HCFA for approval. 42 CFR Section 430.12.

[24] As noted above, the Florida Legislature, in 1996 (in Chapter 96-417) had amended the definition of "intermediate care facility or the developmentally disabled" or "ICF/DD" to reflect that the term applied only to "state-owned and-operated" facilities" and not to privately-operated facilities. It was to these privately-operated facilities that the Legislature was obviously referring when it used the term "facilities formerly known as ICF/DD facilities." Although Judge Ferguson had entered his Order on Motion for Preliminary Injunction in Cramer v. Chiles staying the effective date of Chapter 96-417, Laws of Florida, at the time it enacted Chapter 98-46, Florida Statutes, the Florida Legislature had taken no formal action to undo the change that it had made in 1996 to the definition of "ICF/DD." (In fact, it has yet to take any such action.)

[25] The subsection of Section 409.908, Florida Statutes, that the Proposed Rules would implement (subsection (22)) provides that "[t]his subsection is repealed on July 1, 1999." Therefore, it is not unreasonable, in attempting to assess the potential impact of the Proposed Rules, to look only at the one-year period (July 1, 1998, to June 30, 1999) that Section 409.908(22) will be in effect.

[26] Private ICF/DD providers in Florida, as a group, currently (under the existing plan) receive $117 million in Medicaid payments.

[27] It was not until 1987 that a definition for an "invalid exercise of delegated legislative authority" was added to Chapter 120, Florida Statutes, as was observed in Florida League of Cities v. Department of Environmental Regulation, 603 So. 2d 1363, 1367 (Fla. 1st DCA 1992). See Chapter 87-385, Section 2, Laws of Florida. This was after the case of Department of Environmental Regulation v. Leon County, 344 So. 2d 297 (Fla. 1st DCA 19977) (in which it was held that a "hearing officer, in the exercise of quasi-judicial authority in furtherance of the administrative rule-making process, can determine whether or not a Proposed rule violates the Florida Constitution if adopted") was decided.

[28] A rule is vague if persons of common intelligence must guess as to the rule's meaning and if the language used does not apprise affected persons of the rule's effect on them. See City of St. Petersburg v. Pinellas County Policy Benevolent Association, 414 So. 2d 293 (Fla. 2d DCA 1982).

[29] An "arbitrary" action is "one not supported by facts or logic, or [is] despotic." A "capricious" action is "one which is taken without thought or reason or [is] irrational[ ]." Agrico Chemical Co. v. Department of Environmental Regulation, 365 So. 2d 759, 763 (Fla. 1st DCA 1978). Action taken by an agency that the Legislature has specifically authorized the agency to take is neither arbitrary nor capricious. See Florida Manufactured Housing Association, Inc., v. Department of Revenue, 642 So. 2d 626 (Fla. 1st DCA 1994)(proposed rules that "add nothing whatsoever to the requirements of the law, but instead fit squarely within [statute implemented]" not arbitrary or capricious).

[30] The provisions of Section 120.58, Florida Statutes, following subsection (e) were added in 1996. See Chapter 96-159, Laws of Florida.

[31] Section 120.536(1), Florida Statutes, provides as follows:

> 120.536 Rulemaking authority; listing of rules exceeding authority; repeal; challenge.–
>
> (1) 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, interpret, or make specific the particular 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, 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 the particular powers and duties conferred by the same statute

[32] The Legislature directed Respondent to contain only the growth in expenditures in privately-operated ICF/DDs. It did not order Respondent to take any action to limit expenditure growth in state-run ICF/DDs, or to make any other changes to the existing ICF/DD Methodology. (Of course, if the Legislature wants to limit the growth in expenditures in state-run ICF/DDs, it can accomplish this objective itself by simply appropriating less money for the operation of these facilities. It is not

necessary for Respondent to take any action for such cost containment to be achieved.)

[33] A year prior to adding subsection (22) to Section 409.908, Florida Statutes, the Florida Legislature (in Chapter 96-417, Section 11(1)(e), Laws of Florida) noted that "[t]here are fundamental differences in the respective roles of private and public facilities that serve individuals with developmental disabilities and that these differences justify funding private and public facilities through different funding mechanisms."

[34] Both the "Federal District Court Order and Federal District Court Injunction" were issued before the repeal of the Boren Amendment.

[35] See Hamilton County Board of County Commissioners v. Department of Environmental Regulation, 587 So. 2d 1378, 1386 (Fla. 1st DCA 1991)("The more recent 1988 laws and rules relating specifically to biohazardous waste management control over the pre-1988 laws relating generally to solid waste management. See Peterson v. State, Department of Environmental Regulation, 350 So. 2d 544, 545 (Fla. 1st DCA 1977) (inconsistencies between statutes must be resolved in favor of the last expression of legislative will); Adams v. Culver, 111 So. 2d 665, 667 (Fla. 1959) (a special statute covering a particular subject matter is controlling over a general statutory provision covering the same and other subjects in general terms)").

[36] "It is axiomatic that all parts of a statute must be read together in order to achieve a consistent whole. . . . Where possible, courts must give full effect to all statutory provisions and construe related statutory provisions in harmony with one another." Forsythe v. Longboat Key Beach Erosion Control District, 604 So. 2d 452, 455 (Fla.1992).

[37] While it is true that, under the Supremacy Clause, if a state law [such as subsection (22) of Section 409.908, Florida Statutes.] "actually conflicts with a federal statute or regulation, the state law is invalid" (Public Health Trust of Dade County v. Dade County, 693 So. 2d 562, 564 (Fla. 3d DCA 1996)), determining whether subsection (22) of Section 409.908, Florida Statutes, conflicts with federal law is beyond the scope of an administrative law judge's authority.

[38] The foregoing cases discuss the authority of state administrative agencies. They do not address the authority of federal agencies, like the HCFA, which are charged with the responsibility of reviewing state law (and action taken pursuant thereto) for compliance with applicable federal statutes and regulations. The HCFA is not prohibited from withholding approval of state plans or plan amendments mandated by the

Florida Legislature that do not meet federal requirements. Indeed, it is obligated to withhold its approval under such circumstances. Accordingly, even though the undersigned is without power to invalidate, on the ground that they violate federal law, the changes that Respondent proposes to make to the ICF/DD Methodology pursuant to subsection (22) of Section 409.908, Florida Statutes, the HCFA can still withhold the approval Respondent needs to implement these changes.

[39] The existing ICF/DD Methodology is incorporated by reference in the current version of Rule 59G-6.040, Florida Administrative Code. If the Legislature had disapproved of Respondent's incorporation of the methodology by reference, it undoubtedly would have, in addition to directing Respondent to make "changes in the Medicaid reimbursement methodology, as soon as feasible, to contain the growth in expenditures in facilities formerly known as ICF/DD facilities," also required Respondent to set out the complete text of the revised methodology in its rules rather than simply incorporating the methodology by reference. The Legislature, however, did not impose such an additional requirement. Its failure to have done so reflects its approval of Respondent's incorporation by reference of the ICF/DD Methodology in Rule 59G-6.040, Florida Statutes. See State ex rel. Szabo Food Services, Inc., of North Carolina v. Dickinson, 286 So. 2d 529, 531 (Fla. 1973)("When the Legislature reenacts a statute, it is presumed to know and adopt the construction placed thereon by the State tax administrators.").

[40] As also noted above, "[t]he failure of an agency to follow the applicable rulemaking procedures or requirements set forth in [Chapter 120, Florida Statutes] shall be presumed material; however, the agency may rebut this presumption by showing that the substantial interests of the petitioner and the fairness of the proceeding have not been impaired."

[41] Section 120.541, Florida Statutes, provides as follows:

> 120.541 Statement of estimated regulatory costs.–
>
> (1)(a) A substantially affected person, within 21 days after publication of the notice provided under s. 120.54(3)(a), may submit to an agency a good faith written proposal for a lower cost regulatory alternative to a proposed rule which substantially accomplishes the objectives of the law being implemented. The proposal may include the alternative of not adopting any rule, so long as the proposal explains how the lower costs and objectives of the law

will be achieved by not adopting any rule. If such a proposal is submitted, the 90-day period for filing the rule is extended 21 days.

(b) Upon the submission of the lower cost regulatory alternative, the agency shall prepare a statement of estimated regulatory costs as provided in subsection (2), or shall revise its prior statement of estimated regulatory costs, and either adopt the alternative or give a statement of the reasons for rejecting the alternative in favor of the proposed rule. The failure of the agency to prepare or revise the statement of estimated regulatory costs as provided in this paragraph is a material failure to follow the applicable rulemaking procedures or requirements set forth in this chapter. An agency required to prepare or revise a statement of estimated regulatory costs as provided in this paragraph shall make it available to the person who submits the lower cost regulatory alternative and to the public prior to filing the rule for adoption.

(c) No rule shall be declared invalid because it 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, and no rule shall be declared invalid based upon a challenge to the agency's statement of estimated regulatory costs, unless:

1. The issue is raised in an administrative proceeding within 1 year after the effective date of the rule; and

2. The substantial interests of the person challenging the agency's rejection of, or failure to consider, the lower cost regulatory alternative are materially affected by the rejection; and

3.a. The agency has failed to prepare or revise the statement of estimated regulatory costs as required by paragraph (b); or

b. The challenge is to the agency's rejection under paragraph (b) of a lower cost regulatory alternative submitted under paragraph (a).

(2) A statement of estimated regulatory costs shall include:

(a) A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.

(b) A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.

(c) A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including local government entities, required to comply with the requirements of the rule. As used in this paragraph, "transactional costs" are direct costs that are readily ascertainable based upon standard business practices, and include filing fees, the cost of obtaining a license, the cost of equipment required to be installed or used or procedures required to be employed in complying with the rule, additional operating costs incurred, and the cost of monitoring and reporting.

(d) An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined by s. 120.52.

(e) Any additional information that the agency determines may be useful.

(f) In the statement or revised statement, whichever applies, a description of any good faith written proposal submitted under paragraph (1)(a) and either a statement adopting the alternative or a statement of

the reasons for rejecting the alternative in
favor of the proposed rule.

[42] It would, however, provide the HCFA (which is the appropriate administrative agency to determine whether Respondent has acted in compliance with the procedural requirements imposed by federal Medicaid law) with a basis upon which to withhold approval of the changes Respondent proposes to make to the existing ICF/DD Methodology.

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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 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.

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