STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ANNE Z. BENSON AND ROSE MARIE GIBSON,	)	
Petitioners,	)	
vs.	)	Case No. 02-2533RX
DEPARTMENT OF CHILDREN AND FAMILY SERVICES,	)	
Respondent.	)	

FINAL ORDER

Pursuant to notice, a telephonic hearing was held in Tallahassee, Florida, in this case on February 7, 2003, on the parties' motions for final summary order, before the Division of Administrative Hearings, by its designated Administrative Law Judge, Barbara J. Staros.

APPEARANCES

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For Respondent: Herschel C. Minnis, Esquire
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STATEMENT OF THE ISSUE

Whether Rule 65A-1.714, Florida Administrative Code, is an invalid exercise of delegated legislative authority for reasons described in the Petition to Determine Partial Invalidity of Rule.

PRELIMINARY STATEMENT

Petitioners, Anne Z. Benson, by and through her son and attorney-in-fact, Dr. Andre Benson, and Rose Marie Gibson, by and through her daughter and attorney-in-fact, Anna Marie Ippolito, filed a Petition to Determine Partial Invalidity of Rule with the Department of Children and Family Services (DCFS) on or about June 18, 2002. The Petition was forwarded to the Division of Administrative Hearings on June 24, 2002, and was assigned to the undersigned on June 25, 2002.

A Notice of Hearing was issued on June 27, 2002, scheduling a formal hearing for July 25, 2002. On July 24, 2002, the parties filed a Joint Motion for Abatement and Stipulation in which the parties moved for a continuance and requested an abatement of the case. The parties stipulated as follows:

> 1. This action was filed to challenge the legal sufficiency of Rule 65A-1.714, Florida Administrative Code, with Petitioners contending that the rule in its current form is not consistent with the provisions of Title 42 United States Code Annotated section 1396a(r) and Title 42

Code of Federal Regulations subpart 435.725(c)(4).

2. Petitioners, without waiving their claims, and Respondent, without waiving any of its defenses, have discussed settlement of this case and its related issues, both factual and legal. The parties believe that the process outlined and stipulated to below will adequately address all issues set forth in the petition and end the need for any adjudicatory action in the case.

3. Petitioner agrees to an abatement of the action until November 2002. During the abatement period Respondent agrees to do the following:

A. Publish in the Florida Administrative Weekly no later than August 16, 2002, a notice of rule development.

B. Take all steps necessary to file a notice of final adoption no later than November 2002 concerning a rule that complies with 42 United States Code Annotated section 1396a(r) and 42 Code of Federal Regulations subpart 435.725(c)(4).

C. Provide petitioners' attorneys of record copies of all notices and proposed rule language developed throughout the rulemaking process.

D. Provide petitioners' attorneys of record a copy of the final rule language, as adopted.

E. Modify Petitioners Anne Benson and Rose Marie Gibson's patient responsibilities by deducting their respective health insurance premiums.

> 4. The parties understand and agree that this joint motion and stipulation may be used by either party to support withdrawal and/or dismissal of any administrative Fair Hearing now pending before the Department of Children and Family Services, Office of Appeal Hearings, concerning Petitioner Anne Z. Benson or Petitioner Rose Marie Gibson, or both, and Respondent, pertaining to Respondent's eligibility determinations of February 25, 2002 (for Ms. Benson) and May 15, 2002 (for Ms. Gibson).
>
> 5. Upon final adoption of a rule that complies with 42 United States Code Annotated section 1396a(r) and 42 Code of Federal Regulations subpart 435.725(c)(4), Petitioners agree to voluntarily dismiss these proceedings with prejudice. The notice of voluntary dismissal will be filed by petitioners no later than five (5) days after receipt of a copy of the notice of final adoption.
>
> 6. Upon filing the notice of dismissal with prejudice, Respondent agrees to immediately take all steps necessary to compensate petitioners' attorneys a total of $1,500.00, representing complete compensation for petitioners' costs and attorneys' fees. Payment of such costs and fees will be made no later than ten (10) business days following receipt by Respondent of an order dismissing the case with prejudice.

An Order Granting Continuance and Placing Case in Abeyance was issued on July 24, 2002, requiring a status report to be filed no later than September 25, 2002.

The parties timely filed a Joint Status Report on September 23, 2002, which stated in pertinent part as follows:

1. On July 24, 2002, the case was abated based upon the Joint Motion for Abatement and Stipulation, filed on the same date.

2. Pursuant to Paragraph 3.A. of the stipulation, Respondent published its Notice of Rule Development in the Florida Administrative Weekly on August 2, 2002, in Volume 28, Number 31. See Attachment 1.

3. On August 19, 2002, the State of Florida, Agency for Health Care Administration, sought further clarification from the Center for Medicare and Medicaid Services, in Atlanta, Georgia, of the Center for Medicare and Medicaid Services' Program Issuance Transmittal Notice dated March 5, 1999, which serves as part of the legal and factual basis of this litigation.

4. Specifically, the State indicated that it " . . . is extremely interested in placing reasonable limits upon the extent to which the costs of health insurance premiums may be deducted from a resident's share of cost . . .", to eliminate the risk or probability of expending limited state funds unnecessarily. See Attachment 2.

5. The State reasonably believes that it will receive a response from the Center for Medicare and Medicaid Services within the next few weeks. The response will provide necessary guidance to the State with respect to the pending issue.

6. Respondent requests that this matter be continued for approximately forth-five [sic] (45) days for the purpose of receiving a response from the Center for Medicare and Medicaid Services. Petitioner does not object to this request.

7. The parties do not believe, at this time, that a final hearing will be required

> to resolve this matter. (Emphasis in original)

On September 30, 2002, an Order Continuing Case in Abeyance was issued requiring the parties to file a status report no later than November 15, 2002. The parties filed a Joint Status Report on November 18, 2002, which requested additional time to file a status report and stated:

> The State of Florida has not received a written response from the Center for Medicare and Medicaid Services, as of this date. Moreover, the State has been advised that the reason for "no response" is the unavailability of Ms. Rhonda Cottrell, National Coordinator of Medicaid Alliance for Program Safeguard, at the Center for Medicare and Medicaid Services.

An Order Continuing Case in Abeyance was issued on November 25, 2002, requiring a status report to be filed no later than December 10, 2002.

The parties filed a Joint Status Report on December 10, 2002, which stated:

> 1. On December 9, 2002, the state received a written response from the Centers for Medicare and Medicaid Services to its August 19, 2002 letter. Despite receipt of a response from the Centers for Medicare and Medicaid Services, the state contends it is unable to currently engage in rulemaking.
>
> 2. The Centers for Medicare and Medicaid Services informed the state that the proposal as stated, was not permissible under federal guidelines. It, therefore, denied the state's proposal.

> 3. The state agrees to use its best efforts to pursue and obtain sufficient funding from the upcoming state legislative budgetary sessions to cover the total costs associated with absorbing expenses that would be deducted from a Medicaid recipient's share of cost.
>
> 4. The state further agrees to continue to contact and work with the Centers for Medicare and Medicaid Services to effect a policy approvable by the federal authorities until a policy is developed that could be and is approved by the Centers for Medicare and Medicaid Services.
>
> 5. Wherefore, the parties request a telephonic status conference to discuss final disposition of this case.

The text of the letter dated December 5, 2002, from the Centers for Medicare and Medicaid Services reads as follows:

> The [sic] is in response to your letter dated August 19, 2002 requesting guidance on federal Medicaid requirements pertaining to the post-eligibility treatment of income.
>
> We understand and sympathize with the budgetary constraints faced by the State and the need to conserve Medicaid dollars. However, there are no provisions under Medicaid law to permit a State to exclude amounts for Medicare and other health insurance premiums, deductibles, or coinsurance from the post-eligibility calculations for Medicaid beneficiaries.
>
> Post eligibility calculations are made to determine the amount (if any) that Medicaid reduces its payment to providers, and to determine the amount (if any) by which an individual is liable to contribute to the cost of his/her own health care. After initial Medicaid eligibility has been established, the post-eligibility process

applies to Medicaid beneficiaries who are institutionalized (most commonly to those in nursing facilities), and certain Medicaid beneficiaries receiving home and community-based waiver services.

The State Medicaid agency has the authority to calculate the individual's total countable income, and then deduct certain amounts from that income to determine how much of that income the individual may be required to contribute toward his cost of care. Specifically, the individual's contribution is his or her total income less required deductions for:

- personal needs,
- a family and spouse allowance, if applicable, and
- an amount for medical or remedial expenses not subject to payment by a third party. The medical or remedial care deduction includes Medicare and other health insurance premiums, deductibles, and coinsurance charges and necessary medical or remedial care recognized under State law but not covered under the state plan.
- For institutionalized individuals, the State has the option to also deduct an amount for the maintenance of the individuals' home in the community if the individual is expected to return to the home within six months.

These calculations allow the State to reduce its payment to the provider. It also allows the State to use this amount as the beneficiary's share of the cost of his or her care, i.e., the amount the beneficiary is responsible for paying to the provider.

The State is requesting use of "reasonable limits" to exclude the deduction of certain

health insurance premiums from the post-eligibility calculation; however, neither the statute nor regulations would permit this. The following regulations provide guidance as to why this is not permissible.

- Section 1902(r)(l)(A) requires that the State must take into account amounts for incurred expenses for medical and remedial care that are not subject to payment by a third party.

- Section 1902(r)(1)(A)(i) and regulations 42 CFR 435.725(c)(4)(l) or 435.726(c)(4)(1) require States to deduct amounts for Medicare and other health insurance premiums, deductibles, or coinsurance without limitations.

- Reasonable limits are only applicable to necessary medical or remedial care recognized under State law but not covered under the state plan, as specified under 1902(r)(1)(A)(ii) of the Act and 42 CFR 435.725(c)(4)(ii) or 435.726(c)(4)(ii). Excluding, rather than limiting, necessary medical or remedial care would not be considered a reasonable limit.

Under the post-eligibility process, Florida is required to fully deduct premiums, deductibles, and coinsurance charges (including co-payments) imposed under health insurance programs (including Medicare) and Medicaid state plans. If you need additional guidance or more information regarding this matter, please contact Carol Langord at (404)562-7412, Cathy Kasriel at (404)562-7411 or Renard Murray at (404)562-7417.

The direction given to DCFS in the above letter is similar to a March 5, 1999, transmittal notice issued by the Health Care Financing Administration (HCFA) now known as the

Centers for Medicare and Medicaid Services, which was referenced in the parties' September 23, 2002, Joint Status Report. It reads in pertinent part as follows:

> SUBJECT: Application of Income of Institutionalized Recipients Towards the Cost of Care
>
> This HCFA Program Issuance Transmittal Notice (PITN) is a clarification of long standing Medicaid policy. The Medicare Catastrophic Coverage Act (MCCA) of 1988 amended the Social Security Act by adding §1902(r)(1). This provision codified a requirement that was formerly stated only in Federal regulations. This rule requires States to take into account incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare, as well as health insurance premiums, deductibles, and coinsurance when determining the amount of an institutionalized recipient's income to be applied to cost of his/her care. These provisions also apply to recipients getting home and community-based waiver services.
>
> With the Congressional mandate in mind, we are requesting that all States review their current State Plans and operational procedures to determine if you are in compliance with this provision of the law. If not, States should take action by March 31, 1999 to bring your plan and program into compliance. . . .

A case status conference was conducted by telephone on January 2, 2003. As a result of the telephone conference and by agreement of the parties, a Notice of Hearing was issued scheduling the final hearing for February 7, 2003.

On January 21, 2003, the parties each filed a Motion for Summary Final Order asserting that there were no disputed issues of material fact. Pursuant to a telephone conference call on January 27, 2003, an Amended Notice of Hearing was issued changing the February 7, 2003, hearing to a telephonic hearing for consideration of the parties' motions for summary final order in accordance with Section 120.57(1)(h), Florida Statutes, and Rule 28-106.204(4), Florida Administrative Code.

Oral argument was heard on the parties' motions for summary final order on February 7, 2003. The parties timely filed Proposed Final Orders which have been considered in the preparation of this Final Order.

FINDINGS OF FACT

1. Petitioners Benson and Gibson are nursing home residents in Clearwater and Tampa, Florida, respectively. They are participants of the Institutional Care Program (ICP) which is part of the Medicaid program. Their eligibility to participate in ICP is not disputed.

2. DCFS is the state agency responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual

determination of eligibility. Section 409.902, Florida Statutes.

3. The Rule which is challenged in this proceeding reads as follows:

> 65A-1.714 SSI-Related Medicaid Post-Eligibility Treatment of Income.
>
> <u>After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or ALW/HCBS, the department determines the amount of the individual's patient responsibility. This process is called post-eligibility treatment of income.</u>
>
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
>
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance.
>
> (b) Single veterans or surviving spouses with no dependents residing in medical institutions who receive a reduced VA Improved Pension of $90, or less, are entitled to keep their reduced VA pension payment and shall have $35 of their income protected for their personal need allowance.
>
> (c) If the individual earns therapeutic wages an additional amount of income equal to one-half of the monthly therapeutic wages, up to $111, shall be protected for personal need. This protection is in addition to the $35 personal need allowance.

(d) Individuals who elect hospice services have an amount of their monthly income equal to the federal poverty level protected as their personal need allowance unless they are a resident of a medical institution, in which case $35 of their income is protected for their personal need.

(e) The department applies the formula and policies in 42 U.S.C. § 1396r-5 to compute the community spouse income allowance after the institutionalized individual is determined eligible for institutional care benefits. The standards used are in paragraph 65A-1.716(5)(c), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.

(f) For community hospice cases, a spousal allowance equal to the SSI FBR minus the spouse's own monthly income shall be deducted from the individual's income.

(g) For ICP, income may be protected for the first and last months of eligibility if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility.

(2) For ALW/HCBS, the following deductions shall apply in computing patient responsibility:

(a) An allowance for personal needs in an amount equal to the Optional State Supplementation (OSS) (as defined in Chapter 65A-2, F.A.C.) cost of care plus the OSS personal need allowance.

(b) An amount equal to the SSI FBR minus the spouse's monthly income for the spouse's maintenance needs;

(c) An amount equal to the cash assistance consolidated need standard minus the dependent's income for a spouse with

dependents or for dependents not living with a community spouse. (Emphasis added)

4. Each Petitioner has a monthly health insurance premium expense which is paid to a health insurance provider.

5. DCFS calculated Petitioners' post-eligibility treatment of income. In its determination of Petitioners' patient responsibility (i.e., the amount of money each participant must pay towards their nursing home costs), DCFS did not deduct the cost of each Petitioner's health insurance premium.

6. Subsequent to the commencement of this Rule challenge, DCFS adjusted Petitioners' patient responsibility to take into consideration Petitioners' health insurance premiums. This adjustment was made pursuant to paragraph 3E. of the parties' July 24, 2002, Joint Motion for Abatement and Stipulation as set out in the Preliminary Statement.

CONCLUSIONS OF LAW

7. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding pursuant to Section 120.56(1) and (3), Florida Statutes.

8. Petitioners have proven that they have standing to challenge the Rule which is the subject of this dispute. Respondent argues that since the Agency adjusted Petitioners' patient responsibility to reflect the amount of their monthly

insurance premiums, there is no longer any controversy and, therefore, Petitioners lack standing. However, at the time this Rule challenge was filed, the patient responsibility calculation for Petitioners did not take into account their respective health insurance premiums. They were and are persons substantially affected by the Rule and entitled to bring a Rule challenge pursuant to Section 120.56(1) and (3), Florida Statutes. The stipulation of the parties upon which Respondent relies does not remove Petitioners' right to perfect this challenge. Moreover, the stipulation did not result in a resolution of the case in that the primary remedy sought by Petitioners, i.e., the determination of the invalidity of the Rule, was not accomplished.

9. The party attacking an existing agency rule has the burden to prove that the rule constitutes an invalid exercise of delegated legislative authority. Cortes v. State Board of Regents, 655 So. 2d 132 (Fla. 1st DCA 1995). The challenger's burden is a stringent one. Id.; Charity v. Florida State University, 680 So. 2d 463 (Fla. 1st DCA 1996).

10. The Petition to Determine Partial Invalidity of Fla. Admin. Code R. 65A-1,714 alleges that Rule 65A-1.714, Florida Administrative Code, is an invalid exercise of delegated legislative authority within the context of Section 120.52(8), Florida Statutes.[1/]

11. Petitioners assert that the subject Rule is in violation of Section 120.52(8)(b)(c) and (e), Florida Statutes, in that it exceeds Respondent's rulemaking authority; enlarges, modifies and contravenes the specific provisions of law implemented; and is arbitrary and capricious. Petitioners base this allegation on DCFS' refusal to include Petitioners' health insurance premiums as a deduction which Petitioners assert is impermissible under applicable state and federal law.

12. In the pursuit of state implementation, operation, or enforcement of federal programs, an agency is empowered to adopt rules substantively identical to regulations adopted pursuant to federal law. Section 120.54(6), Florida Statutes.

13. Section 409.902, Florida Statutes, reads in pertinent part:

> . . . The Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. . . .

14. Section 120.52(8), Florida Statutes, reads 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, fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency;

(e) The rule is arbitrary or capricious;

(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.

15. Section 409.919, Florida Statutes, states:

Rules.--The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other

> provisions related to responsibility for the determination of Medicaid eligibility.

16. Federal law provides for the establishment of state plans for medical assistance and the requirements of the state plans must comply with 42 U.S.C. Section 1396a. In particular, Section 1396a requires that the state plan "provide for flexibility in the application of such standards with respect to income by taking into account except to the extent prescribed by the Secretary, the costs (whether in form of insurance premiums, payments made to the State under Section 1396b(d)(2)(B) of this title or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law." 42 U.S.C. Section 1396a(a)(17).

17. Title 42 U.S.C. Section 1396a(r)(1)(A) provides:

> (1)(A) For purposes of sections 1396(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, . . . there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including -
>
> (i) medicare and other health insurance premiums, deductibles, or coinsurance, and

> (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

18. Title 42 C.F.R. Section 435.725 contains the federal regulation for post-eligibility treatment of income of institutionalized individuals. It provides that a state agency must reduce its payments to an institution for services by the amount remaining from the individual's income after certain deductions are applied. The regulation specifies those required deductions from the individual's income to determine patient's share of cost.

19. In particular, 42 C.F.R. Section 435.725(c)(4) provides:

> 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.
>
> * * *
>
> (c) Required deductions. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.
>
> * * *
>
> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not

> subject to payment by a third party, including--
>
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
>
> (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

Rule Challenge Analysis

Section 120.52(8)(b), Florida Statutes

20. Petitioners assert that because Rule 65A-1.714, Florida Administrative Code, provides an exclusive list of all deductions from the patient responsibility and does not permit a deduction for health insurance premiums, the Rule exceeds its grant of rulemaking authority in violation of Section 120.52(8)(b), Florida Statutes.[2/]

21. "The authority to adopt an administrative rule must be based on an explicit power or duty identified in the enabling statute . . . [T]he authority for an administrative rule is not a matter of degree. The question is whether the statute contains a specific grant of legislative authority for the rule, not whether the grant of authority is specific enough." (Emphasis in original) Florida Board of Medicine, et al., v. Florida Academy of Cosmetic Surgery, Inc., et al., 808 So. 2d 243 (Fla. 1st DCA 2002), quoting Southwest Florida

Water Management District v. Save the Manatee Club, Inc., 773 So. 2d 594, 599 (Fla. 1st DCA 2000).

22. Section 409.919, Florida Statutes, requires DCFS to adopt and transfer all rules necessary to comply with federal law to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering Sections 409.901 through 409.906, Florida Statutes. Sections 409.901 through 409.906, Florida Statutes, set forth the statutory framework of the Medicaid program in Florida.

23. Section 409.919, Florida Statutes, gives DCFS broad authority to adopt all rules necessary to assure compliance with and administer the Medicaid program. "The Legislature itself is hardly suited to anticipate the endless variety of situations that may occur or to rigidly prescribe the conditions or solutions to the often fact-specific situations that arise." Avatar Development Corp. v. State, 723 So. 2d 199 (Fla. 1998). Accordingly, DCFS has not exceeded its grant of rulemaking authority concerning the opportunity to adopt a rule(s) on this subject in enacting Rule 65A-1.714, Florida Administrative Code.

Section 120.52(8)(c), Florida Statutes

24. Petitioners assert that the failure by DCFS to permit a deduction for health insurance premiums enlarges, modifies, or contravenes the specific provisions of law implemented in violation Section 120.52(8)(c), Florida Statutes. The specific laws implemented cited as required by Section 120.54(3)(a)1., Florida Statutes, are Sections 409.903. 409.904, and 409.919, Florida Statutes.

25. Sections 409.903 and 409.904 direct the Agency for Health Care Administration to make certain mandatory and optional payments on behalf of persons who are determined to be eligible "subject to the income, assets, and categorical eligibility tests set forth in federal and state law." (Emphasis supplied) Section 409.919, Florida Statutes, as discussed previously, requires DCFS to adopt rules necessary to comply with or administer the Medicaid program "and to comply with federal requirements". (Emphasis supplied) The federal requirements set forth above require the recipients' health insurance premiums to be taken into consideration in the calculation of Petitioners' patient responsibility.[3/]

26. The language of Rule 65A-1.714, Florida Administrative Code, does not enlarge or modify the specific laws implemented. However, the failure to include health insurance premiums in the calculation of a recipient's patient

responsibility is contrary to the federal requirements set forth above, and, therefore, contravenes the specific laws implemented.[4/]

Section 120.52(8)(e), Florida Statutes

27. Petitioners assert that DCFS' failure to incorporate the cost of health insurance premiums in its calculation of a recipient's patient responsibility in Rule 65A-1.714, Florida Administrative Code, is arbitrary and capricious.

28. "A rule is 'arbitrary' only if it is 'not supported by facts or logic,' and 'capricious' only if it is irrational." Florida Board of Medicine v. Florida Academy, supra, at 255, citing Board of Clinical Laboratory Pers. v. Florida Assn. of Blood Banks, 721 So. 2d 317, 318 (Fla. 1st DCA 1998).

29. There is insufficient evidence in the record to determine the status of state and federal law regarding this issue at the time of DCFS' promulgation of the Rule. Accordingly, the record is insufficient to support a conclusion that the Rule is arbitrary or capricious.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

ORDERED:

1. Rule 65A-1.714, Florida Administrative Code, in its omission of including a Medicaid recipient's health insurance premium costs in its calculation of the recipient's patient responsibility, is an invalid exercise of delegated authority.

2. Jurisdiction of the Division of Administrative Hearings is retained for consideration of Petitioner's request for attorney's fees pursuant to Section 120.595(3), Florida Statutes.

DONE AND ORDERED this 12th day of March, 2003, in Tallahassee, Leon County, Florida.

_____
BARBARA J. STAROS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 12th day of March, 2003.

ENDNOTES

1/ Although framed as a partial challenge, Petitioners are actually challenging the validity of the rule because of omissions in its content.

2/ Petitioners assert that the Rule also fails to permit a deduction for medical or remedial care expenses not covered by a third party. However, the few facts presented do not establish that these Petitioners were denied deductions for

medical or remedial care. The Petition only asserts that their health care premiums were not deducted.

3/ See generally Bell v. Agency for Health Care Administration, 768 So. 2d 1203 (Fla. 1st DCA 2000) (Administrative rule dealing with durable medical equipment for Medicaid recipients violates federal law by excluding coverage of benefits that may be medically necessary.)

4/ Contravene is defined as "to go or act contrary to: VIOLATE [~a law]. Webster's Ninth New Collegiate Dictionary (Merriam-Webster, Inc. 1984)

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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 the original notice of appeal with the Clerk of the Division of Administrative Hearings and a 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.