STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GERAUD L MORELAND, (II), THROUGH HIS NEXT FRIEND GERAUD L. MORELAND, SR.; KENNETH GIBSON, THROUGH HIS NEXT FRIEND DIANNA MCCULLOUGH; COLLIN CONE THROUGH HIS NEXT FRIEND SHERRY VARDAS; WILL BAKER, JR., BY AND THROUGH HIS NEXT FRIEND RICHARD MARTIN; AND THE ADVOCACY CENTER FOR PERSONS WITH DISABILITIES, INC.,	)	
Petitioners,	)	
vs.	)	Case No. 08-2199RP
AGENCY FOR PERSONS WITH DISABILITIES,	)	
Respondent.	)	

FINAL ORDER

The final hearing in this case was held on June 25 and 26, 2008, in Tallahassee, Florida, before Eleanor M. Hunter, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES:

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STATEMENT OF THE ISSUES

Whether Proposed Florida Administrative Code Rules 65G-4.0021, 65G-4.0022, 65G-4.0023, 65G-4.0024, and 65G-4.0025 are invalid exercises of delegated legislative authority.

PRELIMINARY STATEMENT

On May 5, 2008, the Petitioners filed a challenge to Proposed Florida Administrative Code Rules 65G-4.0021, 65G-4.0022, 65G-4.0023, 65G-4.0024, and 65G-4.0025. During a telephone conference, on May 13, 2008, the parties agreed to have the final hearing on June 9 and 10, 2008, more than 30 days after the assignment of the administrative law judge on May 6, 2008, as permitted by Section 120.56(1)(c), Florida Statutes (2007). On May 28, 2008, the Petitioners filed a Motion for Continuance, which was granted over objection. The final hearing was re-scheduled for June 25 and 26, 2008.

At the beginning of the final hearing, the Respondent announced its decision to withdraw Proposed Florida Administrative Code Rule 65G-4.0021(3), that read as follows:

> (3) The total billings in any quarter of the state's fiscal year for any service a client is authorized to receive shall not exceed twenty-five percent (25%) of the total annual cost plan budget for that service.

At the final hearing, Petitioners presented the testimony of Sherndina Moreland; Celia S. Feinstein, an expert in needs assessments for persons with developmental disabilities; Sherri Vardas; Geraud L. Moreland, Sr.; Richard F. Martin; Janice Phillips; Deborah J. Linton; and John Bartow Black. Petitioners' Exhibits 1 through 8 were received into evidence. Petitioners requested that the deposition of J. B. Black be admitted in their case-in-chief and it was admitted without objection by the Respondent. On motion of Petitioners, official recognition was taken of H.B. 5087 (2008); Florida Administrative Code Rule 59G-1.010(166); Florida Administrative Code Rule 59G-13.080; Conf. Rep. to H.B. 5001, pp. 61-67 (2008-2009); Conf. Rep. to S.B. 2800, pp. 28-29 (2007-2008); Conf. Rep. to S.B. 7009, pp.20-21 (2007-2008); Office of Program Policy Analysis & Governmental Accountability (OPPAGA) Report No. 08-15 (March 2008); Letter to State Medicaid Directors from the Center for Medicaid and State Operations (Jan. 2001).

Respondent presented the testimony of Jim DeBeaugrine; Linda Mabile; and J. B. Black, Ed.D., an expert in the reliability and validity of assessment instruments. Respondent's Exhibits 8, 9, 12 through 21, 18-A, 19-A, 22-A, 23-A, 24 through 30, 32 through 34, 36 through 41, and 55 through 59 were admitted into evidence. Respondent's Exhibits 1 through 7, 10, 11, 22, 23, 31, 42 through 54 were withdrawn by the Agency. Respondent's request for official recognition of the items listed as numbers 5 and 6 was also granted.

The Transcript of the final hearing was received on July 8, 2008. Proposed Final Orders were filed on July 18, 2008.

FINDINGS OF FACT

1. The Agency for Health Care Administration (AHCA) is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act, called the "Medicaid program." See § 409.902, Fla. Stat. (2008). The Respondent, Agency for Persons with Disabilities (APD), is the responsible agency, as defined in Chapter 393, Florida Statutes (2008), for the operation of the Medicaid Waiver program for developmentally disabled persons.

2. The individual Petitioners are clients in the Medicaid Waiver program. They are eligible for services because they

have a developmental disability, as defined in Subsection 393.063(9), Florida Statutes, which is as follows:

> "Developmental disability" means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

The other Petitioner, the Advocacy Center for Persons with Disabilities, Inc., is a not-for-profit group that represents persons with disabilities.

3. Typically, a person who meets the statutory definition for eligibility has the assistance of a waiver support coordinator (WSC), trained by APD, whose role is described in the Agency for Health Care Administration's Developmental Disabilities Waiver Services Coverage and Limitations Handbook (the "Handbook"). The Handbook has been adopted, by reference, in Florida Administrative Code Rule 59G-13.080(12).

4. The WSC assesses the needs of the person for medical, physical and functional services and assists the individual in selecting the services in development of a support plan. The support plan is individualized, based on the preferences, interests, talents, attributes and needs of the recipient. From the support plan, the WSC develops a proposed cost plan that

reflects the level, intensity, duration, and types of services needed, and the cost of the services.

5. The WSC submits the proposed cost plan for Prior Service Authorization review and approval, by one of the APD-contract companies, MAXIMUS and APS Healthcare. If approved, the eligible person with the documented "medical necessity" for services becomes a waiver client with an approved cost plan for one fiscal year. The WSC is supposed to conduct cost plan reviews at least once a year to determine if a change in circumstances necessitates a change in services and costs.

Rulemaking Authority

6. In 2007, the Florida Legislature amended Section 393.0661, Florida Statute (2008), related to home and community-based services, which are available pursuant to the Medicaid Waiver program, to provide, in part, as follows:

> **§ 393.0661. Home and community-based services delivery system; comprehensive redesign**
>
> The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.
>
> (1) The redesign of the home and community-based services system shall include, at a minimum, all actions necessary

to achieve an appropriate rate structure, client choice within a specified service package, appropriate assessment strategies, an efficient billing process that contains reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, and ensures that family/client budgets are linked to levels of need.

* * *

(b) The agency, with the concurrence of the Agency for Health Care Administration, may contract for the determination of medical necessity and establishment of individual budgets.

(2) A provider of services rendered to persons with developmental disabilities pursuant to a federally approved waiver shall be reimbursed according to a rate methodology based upon an analysis of the expenditure history and prospective costs of providers participating in the waiver program, or under any other methodology developed by the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, and approved by the Federal Government in accordance with the waiver.

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve clients with developmental disabilities in the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods.

* * *

(e) The Agency for Health Care Administration shall also seek federal approval to provide a consumer-directed option for persons with developmental disabilities which corresponds to the funding levels in each of the waiver tiers. The agency shall implement the four-tiered waiver system beginning with tiers one, three, and four and followed by tier two. The agency and the Agency for Health Care Administration may adopt any rules necessary to administer this subsection.

(f) The agency shall seek federal waivers and amend contracts as necessary to make changes to services defined in federal waiver programs administered by the agency as follows:

1. Supported living coaching services shall not exceed 20 hours per month for persons who also receive in-home support services.

2. Limited support coordination services shall be the only type of support coordination service provided to persons under the age of 18 who live in the family home.

3. Personal care assistance services shall be limited to no more than 180 hours per calendar month and shall not include rate modifiers. Additional hours may be authorized for persons who have intensive physical, medical, or adaptive needs if such hours are essential for avoiding institutionalization.

4. Residential habilitation services shall be limited to 8 hours per day. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral

problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. This restriction shall be in effect until the four-tiered waiver system is fully implemented.

5. Chore services, nonresidential support services, and homemaker services shall be eliminated. The agency shall expand the definition of in-home support services to enable the provider of the service to include activities previously provided in these eliminated services.

6. Massage therapy and psychological assessment services shall be eliminated.

7. The agency shall conduct supplemental cost plan reviews to verify the medical necessity of authorized services for plans that have increased by more than 8 percent during either of the 2 preceding fiscal years.

8. The agency shall implement a consolidated residential habilitation rate structure to increase savings to the state through a more cost-effective payment method and establish uniform rates for intensive behavioral residential habilitation services.

9. Pending federal approval, the agency is authorized to extend current support plans for clients receiving services under Medicaid waivers for 1 year beginning July 1, 2007, or from the date approved, whichever is later. Clients who have a substantial change in circumstances which threatens their health and safety may be reassessed during this year in order to determine the necessity for a change in their support plan.

(4) Nothing in this section or in any administrative rule shall be construed to

prevent or limit the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from limiting enrollment, or making any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act.

(5) The Agency for Persons with Disabilities shall submit quarterly status reports to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor regarding the financial status of home and community-based services, including the number of enrolled individuals who are receiving services through one or more programs; the number of individuals who have requested services who are not enrolled but who are receiving services through one or more programs, with a description indicating the programs from which the individual is receiving services; the number of individuals who have refused an offer of services but who choose to remain on the list of individuals waiting for services; the number of individuals who have requested services but who are receiving no services; a frequency distribution indicating the length of time individuals have been waiting for services; and information concerning the actual and projected costs compared to the amount of the appropriation available to the program and any projected surpluses or deficits. If at any time an analysis by the agency, in consultation with the Agency for Health Care Administration, indicates that the cost of services is expected to exceed the amount appropriated, the agency shall submit a plan in accordance with subsection (4) to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of

> the House Fiscal Council or its successor to remain within the amount appropriated. The agency shall work with the Agency for Health Care Administration to implement the plan so as to remain within the appropriation. [Emphasis added.]

7. The statute also continues to provide, as before, that no monetary limit is set for the total budget in a cost plan year for the Mental Retardation and Developmental Disabilities Waiver, also known as the "DD Waiver" or "big waiver," now known as Tier One. It establishes limits of $55,000, and $35,000 a year for newly-created Tier Two and Tier Three Waivers, respectively. Tier Four, also previously known as the Family and Supported Living Waiver, continues to have an annual cost budget limit of $14,792.

Federal Approval

8. AHCA, in consultation with APD, obtained federal approval to implement the four-tiered waiver system to serve clients with developmental disabilities. The Federal Center for Medicaid and Medicare Services (CMS) approved the creation of the Mental Retardation and Developmental Disabilities Waiver, which is now Tier One, in 2003. CMS approved the creation of the Family and Supported Living Waiver, which is now comparable to Tier Four, with a limit on spending of $14,792.00, in 2005. In February 2008, CMS approved Florida's request to implement

Tiers Two and Three with spending limits of $55,000 and $35,000, respectively.

Rulemaking Requirements

9. On December 7, 2007, APD published a Notice of Rule Development and Workshop, in Volume 33, Number 49, Florida Administrative Weekly. On March 28, 2008, APD published the Notice of Proposed Rule and Public Hearing, in Volume 34, Number 13, Florida Administrative Weekly. On May 6, 2008, Joint Administrative Procedures Committee issued the certification of the tier rules, which are challenged in this proceeding.

10. During the rulemaking process, APD invited stakeholders, including family members and organizations representing various different interests in the developmental disability community, to participate in the development of the tier rules.

11. APD and AHCA conducted a Rule Development Workshop on December 21, 2007, and a public hearing on April 24, 2008. Representatives of waiver recipients and family members, WSCs and other service providers, and associations and interest groups for the developmental disabilities waiver community attended the public hearing. At both the rule workshop and the public hearing, APD received oral and written comments.

12. Most speakers opposed the proposed tier rules. A major concern was the potential lack of a mechanism for

"migration" or "transition" among tiers as a client's condition and circumstances change. As a result, the following Subsection (5) was added to Proposed Rule 65G-4.0021:

> (5) The Agency will review a client's tier eligibility when a client has a significant change in circumstance or condition that impacts on the client's health, safety, or welfare or when a change in the client's plan of care is required to avoid institutionalization. The information identifying and documenting a significant change in circumstance or condition that necessitates additional or different services must be submitted by the client's Waiver Support Coordinator to the appropriate Agency Area office for determination.

13. APD presented evidence that the provision for review of tier eligibility based on a "significant change in circumstance or condition" is less onerous than the current requirement for a client to be in "crisis." It also noted that WSCs are well-trained to prepare assessments and to provide appropriate documentation of significant changes in circumstances and conditions.

14. Petitioners' expert testified that the phrase "when a change in the client's plan of care is required to avoid institutionalization" is unnecessarily restrictive, in that it fails to consider the need to maintain a person's quality of life. That interpretation ignores the preceding phrase that

requires consideration of changes "that impact on the client's health, safety, or welfare."

15. Currently, clients who are receiving waiver services have received notice that the tier system was in the process of being implemented and that APD would be providing additional information in the future. As of this time, APD has not made any tier assignments, although preliminary analyses have been conducted by APD and by some WSCs.

16. The evidence demonstrated that APD followed proper rulemaking procedures, including taking into consideration the comments suggesting a procedure for transitions between tiers when warranted.

Tier Assignment Assessment Instrument

17. In addition to the requirement in Subsection 393.0661(3), Florida Statutes (2008), for a valid assessment instrument for the assignment of clients to a tier, Subsection 393.0661(1)(a), Florida Statutes, more specifically provides that:

> (a) The agency shall use an assessment instrument that is reliable and valid. The agency may contract with an external vendor or may use support coordinators to complete client assessments if it develops sufficient safeguards and training to ensure ongoing inter-rater reliability. [Emphasis added].

18. Petitioners noted that the proposed rules lack a provision requiring or designating any assessment instrument.

Petitioners also presented evidence that APD is using the Questionnaire for Situational Information (QSI) as an assessment instrument, and asserted that it has not been tested for reliability and validity. APD is planning to test the QSI and instructed WSCs to begin using it in January 2008, but APD plans to use the Individual Cost Guidelines (ICGs) that were administered through December 2007, not the QSI, as the assessment instrument for use in the tier assignment process. The ICG has been used since 2003, and is administered every three years. WSCs and APD staff were trained, and WSCs certified, after passing examinations, to administer the ICG. The ICG is the approved assessment in the Handbook.

19. The "validity" of the ICG, meaning its usefulness as a tool for its intended purpose and, in this case, the planning of service utilization and costs, was established in a study by Mercer Human Resource Consulting in March 2004.

20. The "reliability" of the ICG, the ability of different raters over time to use it to achieve an acceptably similar range of results was tested by MGT of America. The MGT report of January 19, 2005, indicated an acceptable, fairly consistent inter-rater reliability, after face-to-face interviews and a sample size of 213 or 219, although an ideal sample size would have been 250 or 260 subjects. APD staff and WSCs were trained and certified on the ICG again, when it was revised as to cost

estimates, although the questions and scoring system were not changed, in 2006.

21. Petitioners' expert testified that an assessment instrument, to be valid and reliable for support planning, should be administered every three years, as the ICG has been, and that the ICG is reliable and valid to assess support needs. Petitioners' expert expressed the opinion that the ICG has not been validated for the purpose of making tier assignments.

22. By contrast, APD's expert reasonably testified that, while not appropriate as the sole instrument to be used to assign clients to tiers, the ICG is useful in the process of assessing service needs and costs. Therefore, the ICG is useful to the extent that costs are a factor and, in fact, it is reasonable to conclude that the annual budgeted cost for services is one of the most objective factors in the tier assignment process.

23. Petitioners' argument is essentially that the failure to designate an assessment instrument in the rule renders the rule invalid. That argument ignores the inclusion of the Handbook which does designate the ICG and which is incorporated by reference in Rule 59G-13, the rule that is included in the tier assignment criteria of Florida Administrative Code Proposed Rule 65G-4.0021(1). See Findings of Fact No. 25.

Tier Assignment Process

24. Subsections 393.0661(1) and (3), Florida Statutes (2008), require that appropriate assessment strategies and methods be used in the redesign of the waiver system, and for the assignment of clients to tiers. Petitioners' expert testified that the tier assignment rules create a process that is vague, and that creates arbitrary preconditions, including residency, that take priority over the needs of clients.

25. Proposed Rule 65G-4.0021(1) states that:

> (1) The Agency for Persons with Disabilities will assign clients of home and community-based waiver services for persons with developmental disabilities to one of the four Tier Waivers created by Section 393.0661, Florida Statutes (2007). The agency will determine the Tier Waiver for which the client is eligible and assign the client to that waiver based on the developmental disabilities waiver criteria and limitations provided in Chapters 393 and 409, F.S., Rule Chapter 59G-13, F.A.C., and this rule Chapter and the Agency's evaluation of the following information:
> (a) The client's level of need in functional, medical, and behavioral areas, as determined through Agency evaluation of client characteristics, the Agency approved assessment process, and support planning information;
> (b) The client's service needs as determined through the Agency's prior service authorization process to be medically necessary;
> (c) The client's age and the current living setting; and
> (d) The availability of supports and services from other sources, including natural and community supports.

26. The reference in the Rule to Florida Administrative Code Chapter 59G-13, includes the Handbook that sets forth specific conditions that, with a determination of medical necessity, require specific services. Client characteristics are assessed using APD worksheets reporting on clients' physical abilities, handicapping conditions, and major life activities. Support plan worksheets include data on strengths, communication style, type of residence, goals, capabilities, adaptive or assistive equipment, and medications or, in other words, a rather comprehensive assessment of conditions, circumstances, and needs. In addition, the need for Specialized Services may also be documents by assessments by various health care professional, such as doctor’s prescriptions, physical therapy and mental health behavioral assessments. Strictly medical services are, however, in general, provided under the Medicaid state plan not the waiver plan.

27. The criteria in statutes and the Handbook when read, in pari materia, with Proposed Rule 65G-4.0021(1) provide comprehensive, appropriate strategies and methods for implementing a tier assignment process that is not vague or arbitrary. Repeated statutory references to residential placements, residential facilities, and living situations single out these factors as reasonable and important in making tier

assignments and, therefore, appropriate for inclusion in the rules, unless a specific tier assignment rule contravenes the statute that it purports to implement.

Specific Tier Assignments

28. Section 393.0661 and the rules implementing that comprehensive redesign of the Waiver program expands the levels of services from two to four tiers. The individual Petitioners expressed concern that the application of the proposed tier rules to them will arbitrarily cause a reduction in their services. Those concerns are considered in understanding the challenge to the rules, but the individual Petitioners are not entitled to relief in this challenge to the facial validity of the rules as they would be in a proceeding brought under Sections 120.569 and 120.57, Florida Statutes.

29. Proposed Rule 65G-4.0021(2) provides for a continuation of the existing DD Waiver services for Tiers One, Two, and Three, but not for Tier Four, as discussed in Findings of Fact 53 and 54.

> (2) The services described by the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, July 2007 (hereinafter referred to as the "DD Handbook"), adopted by Rule 59G-13.080, F.A.C. and incorporated herein by reference, are available to clients of the Developmental Disabilities Waiver (hereinafter called "the Tier One Waiver"), the Developmental Disabilities Tier Two Waiver (hereinafter called "the Tier Two

Waiver"), and Developmental Disabilities Tier Three Waiver (hereinafter called "the Tier Three Waiver").

30. APD does not take into consideration all available services in making the tier assignments. For example, adult dental services, emergency response needs, adult day training, and supported employment are not considered. APD explained that need for these types of services transcends tiers and are still available to clients, although recipients admittedly will be requires to prioritize their needs within the monetary caps, established by statute.

31. Subsection 393.0661(3)(a) provides:

> (a) Tier one shall be limited to clients who have service needs that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.

32. Proposed Rule 65G-4.0022, intended to implement tier one, provides:

> 2) Clients living in a licensed residential facility receiving any of the following services shall be assigned to the Tier One Waiver:
> (a) Intensive behavioral residential habilitation services;
> (b) Behavior focus residential habilitation services at the moderate or above level of support; or

(c) Standard residential habilitation at the extensive 1, or higher, level of support; or
(d) Special medical home care.
(3) Nursing service needs that can be met through the Tier Two, Tier Three, or Tier Four Waivers are not "services" or "service needs" that support assignment to the Tier One Waiver.

33. By describing both the residential settings and the level of services required, Proposed Rule 65G-4.0022 describes in logical and reasonable detail the clients, who based on these circumstances, have the most intense needs for Tier One Waiver services.

34. Although Proposed Rule 65G-4.0022 does not define the criteria for intense medical and adaptive needs, by using the Handbook, that is understood to mean an adult who needs personal care assistance with feeding, toileting, and other activities of daily living.

Petitioner Geraud Moreland

35. Petitioner Geraud Moreland II is a 34-year-old man who lives with his parents who both work full-time. He receives waiver services because he had a stroke when he was 18 months old and now suffers from severe seizures. His ICG has not been updated since September 2006. In the interim, he has had significant changes in his medical condition. His epilepsy has caused him to lose skills, including the ability to sign words. Petitioner Moreland currently receives personal care assistance

for most activities of daily living, supported employment, respite care, companion care, and support coordination services that have been determined to be medically necessary under the DD Waiver. These services total more than $70,000 per year.

36. Petitioner Moreland's supported employment services enable him to work cleaning a school for four hours a day, two days a week. He owns a vending machine business. He cleans his 22 machines, takes out the money, and refills the machines with the assistance of his caregiver. There are no available alternatives or natural supports available to substitute for Petitioner Moreland's personal care assistance and supported employment services, and those services are expected to be unavailable if as his parents have been told, he is assigned permanently to Tier Three, as he is already preliminarily assigned.

37. Despite his change in circumstances since 2006, Petitioner Moreland’s family and WSC have not requested a review of his ICG.

38. If, in fact, Petitioner Moreland is assigned to Tier Three, as his parents expect, APD takes the position that he can decide to use the money up to the cap for his biggest outcome goal, supported employment, even though it is not used as a tier assignment criterion. Obviously, other services that he

receives would be reduced, but the monetary cap is set by statute not rule.

Petitioner Collin Cone

39. Petitioner Collin Cone is a 14-year-old boy, who is receiving services under the Consumer Directed Care Plus (CDC+) program. He lives with his mother and she provides his personal care assistance that is included in his total cost plan of approximately $60,000 a year. His last ICG was administered in 2006. Since that time he has been diagnosed with irritable bowel syndrome, scoliosis, and worsening eyesight and leg functions.

40. Based on his WSC's projections, Petitioner Collin's mother believes that, because he lives at home, he will be assigned to Tier Four, which has a cap of $14,792. That amount would not be sufficient to allow her to stay home to provide the personal care assistance that he needs, currently compensated at the rate of $18.00 an hour. Although, APD has indicated that Petitioner Collin's personal care assistance could be transferred to the Medicaid State Plan program, the family has received no information regarding the transfer, and understands that the State Plan prohibits the primary care giver from being the personal care assistance provider.

41. APD’s witness indicated that the CDC+ program for personal care assistance by the primary care giver will continue

in the Waiver program. The cost is being limited, however, as of July 1, 2008, to $15.00 an hour. The Medicaid State Plan is expanding to include personal care assistance, but that would require the use of a State plan provider.

Petitioner Will Baker

42. Petitioner Will Baker is a 77-year-old man, who receives adult dental, support coordination, one-on-one adult training, behavior analysis, incontinence supplies, and residential habilitation services in the DD Waiver program. He has lived in the same group home for at least 10 years and has no family.

43. Petitioner Baker's total cost plan for services is approximately $69,800 a year. His support coordinator expressed the opinion that Petitioner Baker could be placed in Tiers One, Two, or Three, but that he would be a candidate for institutionalization if he is not in Tier One.

44. An APD witness testified that a client assessed with the need for a behavior-focused program in a residential habilitation setting will meet the criteria for intense needs in Tier One. Until the assignments are made, any challenge to Petitioner Baker's tier and services is premature and inappropriate in this rule challenge case.

45. Subsection 393.0661(3)(b) describes Tier Two:

> (b) Tier two shall be limited to clients whose service needs include a licensed residential facility and greater than 5 hours per day in residential habilitation services or clients in supported living who receive greater than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $55,000 per client each year.

46. Proposed Rule 65G-4.0023 describes the Tier Two Waiver as follows:

> The total budget in a cost plan year for each Tier Two Waiver client shall not exceed $55,000. The Tier Two Waiver is limited to clients who meet the following criteria:
> (1) The client's service needs include placement in a licensed residential facility and authorization for greater than five hours per day of residential habilitation services; or
> (2) The client is supported living and is authorized to receive more than six hours a day of in-home support services.

47. Proposed Rule 65G-4.0023 matches the statutory description of Tier Two and does not contravene, enlarge or modify the statue. It is reasonable to include a description of Tier Two to make the tier rules complete, even though the statute has the requisite detail for implementation.

48. Subsection 393.0661(3)(c) creates Tier Three as follows:

> (c) Tier three shall include, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who

live in their family home. Total annual expenditures under tier three may not exceed $35,000 per client each year.

49. The proposed rule to implement the Tier Three statutory provision is:

65G-4.0024 Tier Three Waiver.
(1) The total budget in a cost plan year for each Tier Three Waiver client shall not exceed $35,000. A client must meet at least one of the following criteria for assignment to the Tier Three Waiver:
(a) The client resides in a licensed residential facility and is not eligible for the Tier One Waiver or the Tier Two Waiver; or
(b) The client is 21 or older, resides in their own home and receives Live-in In-Home Support Services and is not eligible for the Tier One Waiver or the Tier Two Waiver; or
(c) The client is 21 or older and is authorized to receive Personal Care Assistance services at the moderate level of support as defined in the DD Handbook.
(d) The client is 21 or older and is authorized to receive Skilled or Private Duty Nursing Services and is not eligible for the Tier One Waiver or the Tier Two Waiver; or
(e) The client is 22 or older and is authorized to receive services of a behavior analyst and/or a behavior assistant.
(f) The client is under the age of 22 and authorized to receive the combined services of a behavior analyst and/or a behavior assistant for more than 60 hours per month and is not eligible for the Tier One Waiver or the Tier Two Waiver.
(g) The client is 21 or older and is authorized to receive at least one of the following services:
(i) Occupational Therapy; or
(ii) Physical Therapy; or
(iii) Speech Therapy; or
(iv) Respiratory Therapy.

50. Tier Three is intended for people who do not qualify for Tier One and Two services, but who live in a residential facility. APD deemed that essential because residential habilitation is not permitted in Tier Four. Subsections (a) and (f) may also include children, and (f) may include children who live in the family home.

51. APD justified the age limits in Tier Three based on the alternative availability of services through the Medicaid State Plan for persons under the age of 21, from the Department of Education for persons under the age of 22 who attend public schools, as well as some vocational rehabilitation services. The exceptions in Subsections (a) and (f) are for any client in a residential facility or one in need of behavioral interventions and assistance for more than 60 hours a month but not at the intensity levels for Tiers One and Two.

52. Section 393.0661(3)(d), Florida Statutes, is a restatement of the existing, most limited level of waiver services.

> (d) Tier four is the family and supported living waiver. Tier four shall include, but is not limited to, clients in independent or supported living situations and client who live in their family home. An increase to the number of services available to clients in this tier shall not take effect prior to July 1, 2008. Total annual expenditures under tier four may not exceed $14,792 per client each year.

53. With regard to Tier Four, Proposed Rules 65G-4.0021 and 65G-4.0025 provide:

> The following services described in the DD Handbook are available to clients assigned to the Tier Four Waiver (presently known as The Family and Supported Living Waiver):
> (a) Adult Day Training;
> (b) Behavior Analysis;
> (c) Behavior Assistance;
> (d) Consumable Medical Supplies;
> (e) Durable Medical Equipment;
> (f) Environmental Accessibility Adaptations;
> (g) In-Home Support Service;
> (h) Personal Emergency Response System;
> (i) Respite Care;
> (j) Support Coordination;
> (k) Supported Employment;
> (l) Supported Living Coaching; and
> (m) Transportation.
>
> 65G-4.0025 Tier Four Waiver.
> (1) The total budget in a cost plan year for each Tier Four Waiver client shall not exceed $14,792 per year.
> (2) Clients who are not eligible for assignment to the Tier One Waiver, the Tier Two Waiver, or the Tier Three Waiver shall be assigned to the Tier Four Waiver. The criteria for the Tier 4 Waiver includes, but is not limited to:
> (a) Clients who are currently assigned to receive services through the Family and Supported Living Waiver unless there is a significant change in condition or circumstance as described in subsection 65G-4.0021(4), F.A.C.; or
> (b) Clients who are under the age of 22 and residing in their own home or the family home, or
> (c) Clients who are dependent children who reside in residential facilities licensed by the Department of Children and Families under Section 409.175 F.S.;

54. Tier Four has been in existence in Florida since the State received federal approval in 2005. Petitioners question the logic of placing most children in Tier Four, although, as APD explained with regard to Tiers Three and Four, children are eligible for comparable services through other programs.

55. Petitioners asserted that DD Waiver services are not available in Tier Four in contravention of the last sentence in Subsection 393.0661(3), which states:

> (3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve clients with developmental disabilities in the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods. All services covered under the current developmental disabilities waiver shall be available to all clients in all tiers where appropriate, except as otherwise provided in this subsection or in the General Appropriations Act. (Emphasis added.)

56. That Subsection also directs that the Family and Supported Living Waiver clients be included in the tier system, and the services listed in the rule are the same as those that have always been available in the Family and Supported Living Waiver program.

CONCLUSIONS OF LAW

57. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. § 120.56, Fla. Stat.

58. Respondents stipulated to the standing of each individual Petitioner and to that of the Advocacy Center for Persons with Disabilities.

59. Subsection 120.56(2)(b), Florida Statutes, provides that Petitioners in a challenge to a proposed rule have the burden of going forward. The Agency has the burden to prove by a preponderance of the evidence that the proposed rule is not an invalid exercise of delegated legislative authority. Florida Board of Medicine v. Florida Academy of Cosmetic Surgery, Inc., 808 So. 2d 243, 251 (Fla. 1st DCA 2002).

60. "Invalid exercise of delegated legislative authority" is defined in Subsection 120.52(8), Florida Statutes, 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. A rule is arbitrary if it is not supported by logic or the necessary facts; a rule is capricious if it is adopted without thought or reason or is irrational; or
> (f) The rule imposes regulatory costs on the regulated person, county, or city which could be reduced by the adoption of less costly alternatives that substantially accomplish the statutory objectives.

61. A rule must be authorized by a grant of rulemaking authority and must implement specific powers and duties provided by the enabling legislation. Southwest Fla. Water Mgt. Dist. v. Save the Managee Club, Inc., 773 So. 2d 594 (Fla. 1st DCA 2000).

62. Section 393.0661, Florida Statutes (2008), specifically grants rulemaking authority to APD to implement the Tier Waiver system and it must be given some meaning regardless of other provisions of state or federal law.

63. APD has established that it complied with the rulemaking procedures of Section 120.54, Florida Statutes (2007), including having received, with AHCA, the necessary federal approval to implement the statute.

64. The proposed rules are not invalid because they do not designate an assessment instrument for tier assignments. The assessment instrument is identified in the Handbook that is

listed in the rule as providing additional criteria for tier assignments. The ICG questions and scoring have not been modified, although costs reflecting group home rates were adjusted in 2006. The argument that any change in the assessment instrument would not be subject to challenge, because it is not designated by rule, is not supported by the fact that the Handbook designation of ICG was previously challenged, when the ICG was held valid and reliable. Florida Association of Rehabilitation Facilities, Inc. v. Dep't of Children and Family Services, etc., DOAH Case Nos. 04-0216RP and 04-0258RP (F.O. 4/29/05).

65. As an instrument that is valid and reliable for predicting costs, the ICG can be used reasonably and logically as a part of the tier assignment process. With the ICG information and other comprehensive parts of the assessment process, APD established that it has developed appropriate strategies for making tier assignments that are not vague.

66. Petitioners allege that the proposed rules are "arbitrary" and "capricious." A rule is "arbitrary" if it is not supported by logic or the necessary facts. A rule is "capricious" if it is adopted without thought or reason or is irrational. See § 120.52(8)(e), Fla. Stat. (2007).

67. APD demonstrated by a preponderance of the evidence that it is logical to consider some but not all available

services in making tier assignments. Those services that are excluded were explained to be reasonably those that may be needed by people in all tiers.

68. Some criteria are repeated or duplicated in various parts of the rule or in the documents it references, including natural and community supports, and the support plan. There has been no legal authority cited for the proposition that a rule that is repetitive is invalid.

69. Petitioners' argument that "all developmental disabilities waiver services must be available in all tiers" is not supported by a reading of Subsections 393.0661(3) or (3)(d), Florida Statutes. The services listed in Tier Four are consistent with the statute.

70. Proposed Rule 65G-4.0021, that includes references to the DD Handbook, other criteria for tier assignments, a list of Tier Four services, and the ability to review tier eligibility if circumstances or conditions change, is not invalid.

71. Tier Four age limitations were logical and valid considering other available services. There is no irrational age limitation as found in Esteban v. Cook, et al., 77 F. Supp. 2d 1256 (US Dist. Ct. SD Fla. 1999).

72. The levels of needs and services for Tiers One, Two, and Three are described in detail in the Handbook. The rule criteria for tier assignments are consistent with the statute

and are not vague, even though WSCs and APD staff have to be trained to apply the criteria with reasonable consistency. See Florida East Coast Industries Inc., et al. v. State, Dep't. of Community Affairs, 677 So. 2d 357 (Fla. 1st DCA 1996).

73. The Tier Rules, 65G-4.0021, 65G-4.0022, 65G-4.0023, 65G-4.0024, and 65G-4.0025, based on a preponderance of the evidence presented by APD, are not invalid exercises of delegated legislative authority.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

APD's Proposed Rules 65G-4.0021, 65G-4.0022, 65G-4.0023, 65G-4.0024, and 65G-4.0025 are not invalid exercises of delegated legislative authority.

DONE AND ORDERED this 6th day of August, 2008, in Tallahassee, Leon County, Florida.

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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.