STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

LAS MERCEDES HOME CARE CORP., )
)
Petitioner, )
)
vs. ) Case No 10-0860RX
)
AGENCY FOR HEALTH CARE )
ADMINISTRATION, )
)
Respondent. )
_______________________________ )

## FINAL ORDER

Administrative Law Judge Eleanor M. Hunter held a final hearing in this case on May 19, 2010, by video teleconference between sites in Tallahassee and Miami, Florida.

## APPEARANCES

For Petitioner: Andrew S. Ittleman, Esquire
Fuerst, Humphrey, Ittleman, P.L.
1001 Brickell Bay Drice, Suite 2002
Miami, Florida 33131

For Respondent: Andrew T. Sheeran, Esquire
L. William Porter, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

## STATEMENT OF THE ISSUE

The issue is whether a rule which requires that staff be directly employed by or under contract with a Medicaid home health agency, and that such agencies issue either W-2 or 1099 tax forms to

individuals on their staffs, constitutes an invalid exercise of delegated legislative authority.

PRELIMINARY STATEMENT

On September 30, 2008, the Respondent Agency for Health Care Administration ("Respondent" or "AHCA") issued a Final Audit Report seeking to recover from Petitioner Las Mercedes Home Care Corporation ("Petitioner" or "Las Mercedes") Medicaid overpayments of $878,843.93 and assessing a fine of $1,000. Petitioner timely requested an administrative hearing, and the case was referred to the Division of Administrative Hearings (DOAH) on November 12, 2008, and assigned DOAH Case No. 08-5653MPI ("the MPI case"). That case was initially set for hearing on February 17 and 18, 2009, but was continued on joint motion of the parties and rescheduled for May 4 and 5, 2009. On March 23, 2009, AHCA filed an Opposed Motion to Amend Final Audit Report and Las Mercedes requested and was granted additional time to respond to the Motion. On agreed motions for continuance, the final hearing was continued three more times to permit hearings on and consideration of potentially dispositive motions.

An evidentiary hearing on the Opposed Motion to Amend Final Audit was held on June 8, 2009. Following the filing of post-hearing submissions and the Transcript, the Motion to Amend was granted on June 24, 2009. After conducting additional discovery, on November 30, 2009, AHCA filed an Opposed Motion to Relinquish

Jurisdiction and, on the same day, Las Mercedes filed a Motion for Recommended Order and/or Motion to Dismiss. The Motion to Dismiss was premised, in part, on Las Mercedes's claim that AHCA was applying a rule that conflicted with its statutory authority. At a motion hearing on January 11, 2010, AHCA objected to consideration of the validity of a rule in the MPI case, a case that was filed pursuant to Section 120.57, Florida Statutes (2009). Las Mercedes, on February 17, 2010, filed this rule challenge case, which was assigned DOAH Case No. 10-0860RX and, at the request of the parties, consolidated with the MPI case.

At the final hearing, held on May 19, 2010, the parties chose to present arguments and evidence related only to the rule challenge case. As a result, the cases have been unconsolidated and this Order applies only to the rule challenge.

At the hearing, over Las Mercedes's objection that the issues are solely legal, AHCA presented the testimony of two witnesses: James K. Hampton, AHCA statewide fraud and abuse liaison for Medicaid; and Ann Menard, AHCA supervisor of the Health Care Unit in the Bureau of Health Facility Regulation. AHCA's Exhibits 1, Page 1-8 of the Handbook dated July 2008; and 2, Section 400.462, Florida Statutes (2009), were received in evidence. The one-volume final hearing Transcript was filed on June 10, 2010. The parties waived the 30-day deadline for the issuance of a final order so that they could file Proposed Final Orders, as they did,

on July 2, 2010. Unless otherwise specified, all references to Florida Statutes are to the 2009, publication.

## FINDINGS OF FACT

### The Parties

1. Petitioner Las Mercedes is a licensed home health agency. From July 1, 2004, through June 30, 2006 ("the audit period"), Las Mercedes was also an enrolled Medicaid provider of home health care services. Services were provided through so-called "staffing agreements" with twenty-two companies. Las Mercedes, together with the patient's physician, determined the scope, duration, and plan of care, and it controlled, coordinated, and evaluated the services provided. Las Mercedes established the policies and procedures for submitting progress and clinical notes, scheduling visits, periodic patient evaluation, and the payment for services. (See Stipulation of Facts filed October 6, 2009, in DOAH Case No. 08-5653MPI.)

2. Respondent AHCA is the state agency responsible for administering the joint federal-state Medicaid Program in Florida. It is responsible for, among other things, reimbursing providers for services to Medicaid recipients. In an Amended Final Audit, AHCA determined that Las Mercedes was overpaid $878,843.93 in Medicaid funds between July 1, 2004, and June 30, 2006. The allegation was based on the undisputed fact that Las Mercedes did not issue W-2s or 1099 tax forms to the individuals who provided

home health care, but instead issued 1099s to the twenty-two staffing companies. As a result, AHCA concluded that the staff was not employed by or under contract with Las Mercedes as required by Rule.

The Rule Challenge

4. The challenged Rule is a provision from the Florida Medicaid Home Health Services Coverage and Limitations Handbook, which is incorporated by reference by Florida Administrative Code Rule 59G-4.130. On page 1-8 of the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2008 edition, the Rule is as follows:

> Home health services are provided by qualified health care professionals who are directly employed by or under contract with a home health agency that is enrolled in the Medicaid Home Health Services Program.
> Employed or contracted means that the home health agency provides a W-2 or 1099 tax form for the individual.
> The home health agency must ensure that all staff (employed or contracted) who provide home health services are qualified and licensed.

5. By contrast, Subsection 400.462(9), in establishing licensure requirements for home health agencies has the following definition of a direct employee:

> "Direct employee" means an employee for whom one of the following entities pays withholding taxes: a home health agency; a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that

> has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.

6. AHCA agrees that the Medicaid Rule excludes employee staffing agreements that are permitted by the licensure statute.

7. Las Mercedes asserts that the Rule is an invalid exercise of AHCA's delegated legislative authority because: (1) it is ultra vires; (2) the definition of "employed by or under contract with" is in irreconcilable conflict with the definition of "direct employee" in Subsection 400.462(9), Florida Statutes; and (3) it is arbitrary and capricious and, therefore, unenforceable.

8. Las Mercedes also claims that the Rule exceeds the authority granted to AHCA by federal law. It interprets the law as requiring that the licensure standard apply equally to the Medicaid and non-Medicaid providers. That view is based on the language in 42 U.S.C. § 1396(a)(33)(B), which is, in relevant part, as follows:

> [A state plan for medical assistance must provide] that, except as provided in section 1919(g) [42 USCS § 1396r(g)], the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a) [42 USCS § 1395aa(a)], or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title [42 USCS §§ 1396 et seq.] the function of determining whether institutions and agencies meet the

> requirements for participation in the program.

9. The "agency utilized by the Secretary, as provided in 42 U.S.C. § 1395aa(a)" refers to the following:

> (a) Use of State agencies to determine compliance by providers of services with conditions of participation. The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency. (Emphasis added.)

10. In Las Mercedes' view of the federal law, the qualifications for being licensed and being a Medicaid provider are expected to be the same. It appears that nothing prohibits that from being the case. Las Mercedes also asserts that the Rule conflicts with 42 C.F.R. § 447.204, which states:

> The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

11. In this record, however, Las Mercedes presented no evidence regarding payments or, as Las Mercedes implies, the extent to which Medicaid services may or may not be adequate without the use of the staffing arrangements permitted under Subsection 400.462(9), Florida Statutes.

12. Las Mercedes also argues that the Rule is arbitrary and capricious. AHCA, it says, cannot articulate a valid reason why licensed home health personnel must receive a tax form directly from a Medicaid provider. Further, Las Mercedes asserts, the Rule is not logically related to the stated purposes of ensuring health, welfare, and safety, and avoiding waste, fraud, and abuse.

The Agency's Explanation for the Rule

13. AHCA is responsible for the licensure of home health agencies pursuant to Part III of Chapter 400, Florida Statutes, more specifically Sections 400.461 through 400.5185, known as the "Home Health Services Act." Florida Administrative Code Rules in Chapter 59A-8 implement the provisions of the Home Health Services Act by setting minimum standards for licensure.

14. To be enrolled as a Medicaid provider, a home health agency must not only be licensed, but also must have entered into a Medicaid provider agreement, a voluntary contract between AHCA and the agency. See § 409.907, Fla. Stat. The provisions related to Medicaid are found in Sections 409.901 through 409.920, Florida Statutes. Florida Administrative Code Rule 59G-4.130, including the language that is challenged, cites as enabling statutes Sections 409.905, 409.908, and 409.9081, Florida Statutes, not the licensure provisions in Chapter 400.

15. AHCA contends that challenged Rule is a logical, rational imposition of higher standards than the minimum standards for licensure on those home health agencies that are also Medicaid providers. Its purpose is to ensure health, safety, and welfare of Medicaid recipients, and to curb waste, fraud and abuse. To that end, AHCA maintains that the Rule allows it to exercise greater oversight over the Medicaid program.

16. AHCA concedes that a violation of the challenged Rule would not in and of itself result in any action to deny or revoke a license, although exclusion from the Medicaid program would result in revocation or denial of a license.

## CONCLUSIONS OF LAW

17. Las Mercedes has standing, and it has the burden of proving the invalidity of the challenged existing rule by a preponderance of the evidence. § 120.56(3)(a), Fla. Stat.; and Greynolds Park Manor, Inc. v. Department of Health and Rehabilitative Services, 491 So. 2d 1157 (Fla. 1st DCA 1986).

### DOAH Jurisdiction in Medicaid Rule Challenge Cases

18. AHCA maintains that DOAH has no jurisdiction to invalidate a Medicaid rule because federal law prohibits DOAH from reviewing Medicaid rules.

19. Medicaid was established by Congress in Title XIX of the Social Security Act, which authorizes federal grants to States for the Medicaid Program. 42 U.S.C. § 1396 et seq. The Medicaid

Program is financed by the federal and state governments, but each state is required to designate a single state agency to administer or to supervise the administration of Medicaid. 42 U.S.C. § 1396a(a)(5). In accordance with 42 C.F.R. Section 431.10(e), "[t]he authority of the [designated Medicaid state] agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State." 42 C.F.R. § 431.10(e)(2). Therefore, AHCA interprets federal law as prohibiting DOAH review of Medicaid rules.

20. In support of its argument, AHCA cited Orthopaedic Hosp. v. Kizer, 1992 U.S. Dist. LEXIS 21123 (C.D. Cal. Oct. 5, 1992); and Vogel v. Perales, 1983 U.S. Dist. LEXIS 17032 (S.D.N.Y. May 11, 1983).

21. In Orthopaedic Hosp. v. Kizer, the Court explained that the agency could not use a statute as an excuse for inadequate rulemaking, as follows:

> In the Court's view, however, Section 1418.4.11--like all of the statutory enactments at issue in this case, in fact--gave the Department fairly wide discretion in implementing the basic changes outlined in the statute. Thus the Department was not relieved from obligations it otherwise would have had merely by virtue of the role played by the state legislature in new rates set[ting].

* * *

> At the very least, the fact that the legislature may have considered "efficiency, economy, and quality of care" in making the basic determination that cesarean and non-cesarean delivery rates should be equalized does not relieve the Department of the obligation to further consider "efficiency, economy and quality of care" in exercising what discretion it had in implementing the legislature's general mandate. There is no evidence that the Department did consider the relevant factors in this limited sense. And in any event, nor is there adequate evidence in the record demonstrating that the state legislature at any time considered "efficiency, economy, and quality of care" in connection with the equalization of rates for cesarean add non-cesarean deliveries.

1992 U.S. Dist. LEXIS 21123 at p. 24.

22. In Vogel v. Perales, supra, the State Department of Social Services ("DSS") was the designated Medicaid agency, but the Department of Health ("DOH") established the list of drugs approved for Medicaid reimbursement. The Court described the concerns as follows:

> Two problems are apparent. First, 42 C.F.R. § 431.10(e) states that the State Medicaid agency's authority "must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State." . . .. DSS has divested itself of authority to reimburse for non-listed drugs. Second, the hearing requirement established by the federal regulations is nullified by this scheme. A hearing is required, inter alia, when a recipient "requests it because he believes the agency has taken an action erroneously." 42 C.F.R. § 431.220(a)(2). By abdicating authority over drug reimbursement to DOH, however, DSS is unable

to grant any relief through its hearing procedure.

1983 U.S. Dist. LEXIS 17032.

23. More applicable here is Greynolds Park Manor, Inc. v. Department of Health and Rehabilitative Services, 491 So. 2d 1157 (Fla. 1st DCA 1986), holding that a party who was substantially affected by a rule determining Medicaid overpayments could challenge the rule at DOAH.

24. DOAH has, in the past, exercised its jurisdiction to determine the validity of Medicaid rules. See, e.g., Home Delivery Incontinent Supplies Co., Inc., vs. Agency for Health Care Admin., 2008 Fla.Div.Adm.Hear.LEXIS 205, Case No. 07-4167RX (DOAH F.O. April 18, 2008)(holding that a rule disqualifying out-of-state providers of durable medical equipment was invalid as not supported by enabling statutes); Manor Pines Convalescent Center v. Agency for Health Care Admin., DOAH Case No. 06-3489 (F.O. April 25, 2007)(invalidating low occupancy reimbursement rate reduction rule as arbitrary, capricious, and not supported by and contravening statutory authority); Consult Care, Inc. v. Agency for Health Care Admin., DOAH Case No. 99-2497RX, per curiam aff'd 793 So. 2d 938 (Fla. 1st DCA 2001)(invalidating, as without authority, arbitrary and capricious limitations on Medicaid reimbursement of certain services when provided in mobile units); and Bell v. Agency for Health Care Admin., DOAH

Case. No. 99-2060RX, rev. and remanded at 768 So. 2d 1203 (Fla. 1st DCA 2000)(invalidating a rule that created a disparity in coverage for Medicaid recipients based on age as arbitrarily and unreasonably excluding coverage of benefits that may be medically necessary).

Framework for the Rule Challenge Analysis

24. The term "invalid exercise of delegated legislative authority is defined in Section 120.52(8), Florida Statutes. The following provisions are relevant to this case:

> "Invalid exercise of delegated legislative authority" means action that goes beyond the powers, functions, and duties delegated by the Legislature. A proposed or existing rule is an invalid exercise of delegated legislative authority if any one of the following applies:
>
> * * *
>
> (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.;
>
> * * *
>
> (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
>
> * * *

> A grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only rules that implement or interpret the specific powers and duties granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary and capricious or is within the agency's class of powers and duties, nor shall an agency have the authority to implement statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than implementing or interpreting the specific powers and duties conferred by the enabling statute. (Emphasis added.)

Analysis for 120.52(8)(b) and (c)

25. The parties agree that an appropriate analytical framework for Subsections 120.52(8)(b) and (c) is that set forth in Home Delivery Incontinent Supplies Co. v. Agency for Health Care Administration, 2008 Fla.Div.Adm.Hear.Lexis 205, Case No. 07-4167RX (DOAH F.O. April 18, 2008), although AHCA takes the position that the case was wrongly decided.

26. In the Home Delivery analysis, Judge Van Laningham raised four questions: (1) whether the agency has been delegated the power to make rules; (2) what is the specific power or duty the agency is exercising in implementing the Rule; (3) whether that power is among the powers that the legislature has granted to the agency;

and (4) whether the rule actually implements or interprets the powers granted.

27. The parties agree that AHCA has been granted rulemaking authority by Section 409.919, Florida Statutes, as follows:

> The agency shall adopt any rules necessary to comply with or administer ss 409.904-409.920 and all rules necessary to comply with federal requirements.

28. The parties disagree what specific power or duty AHCA is exercising. Las Mercedes framed it as an attempt to "define how a home health agency pays its employees." AHCA says it is regulating "who may and who may not provide home health services to Medicaid recipients." Neither seems to state precisely what is happening in this case. If, as described by Judge Van Laningham, one "zooms in" then the focus might be on the issue of pay. If one "zooms out" then perhaps the issue is who provides the services. In between the two and in its most basic terms in this case, AHCA is defining the business relationship of Medicaid-enrolled home health agencies and their employees or contract staff using the nature of the tax form it issues as determinative.

29. To decide "whether the specific power or duty, as defined, is among the specific powers or duties delegated to the [AHCA] by the legislature," it is necessary to refer to the enabling statutes.

30. As noted, the challenged Rule is found on page 1-8 of the Handbook, dated July 2008, which is incorporated by reference in Florida Administrative Code Rule 59G-4.130. In Rule 59G-4.130, the cited authorities are Sections 409.905 (entitled mandatory Medicaid services), 409.908 (concerning reimbursement of Medicaid providers), and 409.9081 (on copayments), Florida Statutes. The question, then, is whether these statutes delegate to AHCA the authority to define the business relationships between its staff and a Medicaid-enrolled home health agency when home health services are being provided to Medicaid recipients.

31. In general, with regard to mandatory Medicaid services, Section 409.905, which provides, in part, as follows:

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or 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.
> (Emphasis added.)

32. AHCA points specifically to Subsection 409.905(4), Florida Statutes, which states:

> The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefore, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.
>
> (a) In providing home health care services, the agency may require prior authorization of care based on diagnosis, utilization rates, or billing rates. The agency shall require prior authorization for visits for home health services that are not associated with a skilled nursing visit when the home health agency billing rates exceed the state average by 50 percent or more. The home health agency must submit the recipient's plan of care and documentation that supports the recipient's diagnosis to the agency when requesting prior authorization.
>
> (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When

implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician.

2. The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.

3. The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for

> skilled nursing services, the frequency and duration of the services.
> 6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.
> (Emphasis added.)

33. The only requirement for a Medicaid-enrolled home health agency that is expressed in Subsection 409.905(4), Florida Statutes, is licensure pursuant to Chapter 400. The only business relationship that it requires regulating is that between the physician and the home health agency.

34. Section 409.908, concerning reimbursement of Medicaid providers begins as follows:

> 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. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions

> for filing cost reports, if applicable, shall also apply to Medicaid cost reports. 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.

35. More specifically, in connection with the reimbursement of home health agencies, Subsection 409.908(9), Florida Statutes, provides that:

> A provider of home health care services or of medical supplies and appliances shall be reimbursed on the basis of competitive bidding or for the lesser of the amount billed by the provider or the agency's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the agency's established maximum allowable amount, whichever amount is less.

36. No express or implied authorization to regulate the business relationship between a home health agency and its employees or contractors is found in Section 409.908, Florida Statutes.

37. The final enabling statute cited as authority for the Rule is Section 409.9081, Florida Statutes, concerning copayments and providing that:

> (1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:
> (a) Hospital outpatient services: up to $3 for each hospital outpatient visit.
> (b) Physician services: up to $ 2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463.
> (c) Hospital emergency department visits for nonemergency care: 5 percent of up to the first $300 of the Medicaid payment for emergency room services, not to exceed $ 15.
> (d) Prescription drugs: a coinsurance equal to 2.5 percent of the Medicaid cost of the prescription drug at the time of purchase. The maximum coinsurance shall be $ 7.50 per prescription drug purchased.
> (2) The agency shall, subject to federal regulations and any directions or limitations provided for in the General Appropriations Act, require copayments for the following additional services: hospital inpatient, laboratory and X-ray services, transportation services, home health care services, community mental health services, rural health services, federally qualified health clinic services, and nurse practitioner services. The agency may only establish copayments for prescribed drugs or for any other federally authorized service if such copayment is specifically provided for in the General Appropriations Act or other law.
> (3) In accordance with federal regulations, the agency shall not require copayments of the following Medicaid recipients:
> (a) Children under age 21.

(b) Pregnant women when the services relate to the pregnancy or to any other medical condition which may complicate the pregnancy up to 6 weeks after delivery.
(c) Any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all but a minimal amount of her or his income required for personal needs for medical care costs.
(d) Any individual who requires emergency services after the sudden onset of a medical condition which, left untreated, would place the individual's health in serious jeopardy.
(e) Any individual when the services or supplies relate to family planning.
(f) Any individual who is enrolled in a Medicaid prepaid health plan or health maintenance organization.
(4) No provider shall impose more than one copayment for any encounter upon a Medicaid recipient.
(5) The agency shall develop a mechanism by which participating providers are able to identify those Medicaid recipients from whom they shall not collect copayments.
(6) [As created by s. 5, ch. 96-280.] This section does not require a provider to bill or collect a copayment required or authorized under this section from the Medicaid recipient. If the provider chooses not to bill or collect a copayment from a Medicaid recipient, the agency must still deduct the amount of the copayment from the Medicaid reimbursement made to the provider.
(6) [As created by s. 5, ch. 96-387.] This section does not require a provider to bill or collect from the Medicaid recipient any copayment authorized by subsection (1). Regardless of whether the provider bills or collects the copayment, the agency shall deduct the amount of the copayment from the Medicaid reimbursement to the provider.

38. Nothing in Section 409.9081, Florida Statutes, authorizes the challenged Rule.

Conflict with Subsection 400.462(9)

39. Subsection 400.462(9), Florida Statutes, defines a direct employee of a home health agency as follows:

> "Direct employee" means an employee for whom one of the following entities pays withholding taxes: a home health agency; a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.

40. AHCA concedes that the definition in the Rule of "employed or contracted" meaning "the home health agency provides a W-2 or 1099 tax form for the individual" is more restrictive than the definition of "direct employee" in Subsection 400.462(9), Florida Statutes.

41. AHCA asserts that the different definitions have different purposes and that the Rule promulgated under Chapter 409.901-920, Florida Statutes, relating to the Medicaid home health agencies is intentionally more restrictive that the rules promulgated under Subsection 400.462(9) relating to Chapter 400, Florida Statutes, on minimum licensure standards.

42. There is, however, no indication that the Legislature contemplated or the federal government requires the difference. To the contrary, the federal provisions quoted above in Findings of

Fact 6 and 7, and the reference in Subsection 409.905(4) to the Part III of Chapter 400, Florida Statutes, suggest that the use of the same definition is, in fact, not only acceptable but is as restrictive as the federal government requires and the State Legislature authorized.

43. Given the existence of the definition in Subsection 400.462(9), Florida Statutes, there is also no implied necessity for another definition.

Rule Challenge Analysis for 120.52(8)(e)

44. AHCA gave as the justification for the more restrictive definition ensuring the health, safety, and welfare of Medicaid recipients, and avoiding waste, fraud, and abuse. Las Mercedes claims the Rule is arbitrary and capricious and is, therefore, unenforceable.

45. "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." § 120.52(8)(e), Fla. Statutes.

46. The analysis for whether a rule is arbitrary and capricious is (1) whether the rule is supported by logic or the necessary facts; and (2) whether the rule was adopted without thought or is irrational. § 120.52(8)(e), Fla. Stat.

47. Las Mercedes presented no evidence concerning the thought or any lack of thought that went into the challenged Rule at the time of its adoption.

48. AHCA presented evidence, through the testimony of its witnesses, that the challenged Rule is intended to protect "the health, safety and welfare of our vulnerable recipient population [by] hav[ing] adequate safeguards in place, such as background screenings to ensure that individuals that may present with a propensity or indication of impropriety are not offering services to our Medicaid recipients." The Rule is, according to AHCA, a means ". . . to counter fraud, waste, and abuse."

49. AHCA's Medicaid fraud and abuse liaison also testified that the requirements for enrollment in the Medicaid program are set forth in Section 409.907, Florida Statutes. That Section provides, in relevant part, the following:

> The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.
> (1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Medicaid

program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts . . .
(2) Each provider agreement shall be a voluntary contract between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient . . .
(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:
(a) Have in its possession at the time of signing the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional or facility license pertinent to the services or goods being provided, as required by the state or locality in which the provider is located . . .

* * *

(i) At the option of the agency, provide proof of liability insurance and maintain such insurance in effect for any period during which services or goods are furnished to Medicaid recipients.

* * *

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location . . .. The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency . . .. [t]he agency may also require that Medicaid providers reimbursed on a fee-for-services

basis or fee schedule basis which is not cost-based, post a surety bond . . ..
[Background information must include:
(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.
(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government . . ..
(c) Full and accurate disclosure of any financial or ownership interest . . . in any other Medicaid provider or health care related entity . . ..
(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.
(8)(a) Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check [by] the Department of Law Enforcement [and] the Federal Bureau of Investigation.

* * *

(d) Proof of compliance with the requirements of level 2 screening under s. 435.04 [and] level 1 screening under s. 435.03 conducted within 12 months prior to the date that the Medicaid provider application is submitted to the agency shall meet the requirement that the Department of Law Enforcement conduct a state criminal history record check.
(9) Upon receipt of a completed, signed, and dated application, and completion of any necessary background investigation and criminal history record check, the agency must either:

(a) Enroll the applicant as a Medicaid provider upon approval of the provider application . . . or
(b) Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern; the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success, and patient outcomes of the provider for the services that it is making application to provide in the Medicaid program . . .
(a) . . . made a false representation . . .;
(b) Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in, Florida's Medicaid program or any other state's Medicaid program . . .;
(c) Been convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare . . .;
(d) Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services; . . ..
(e) Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
(f) Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
(g) Been convicted under federal or state law of a crime punishable by imprisonment of a year or more which involves moral turpitude;

> (h) Been convicted in connection with the interference or obstruction of any investigation into any criminal offense listed in this subsection;
> (i) Been found to have violated federal or state laws, rules, or regulations governing Florida's Medicaid program or any other state's Medicaid program, the Medicare program . . .;
> (j) Been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided,
> (k) Failed to pay any fine or overpayment properly assessed under the Medicaid program
> . . .
> (12) Licensed, certified, or otherwise qualified providers are not entitled to enrollment in a Medicaid provider network. (Emphasis added.)

50. The requirements for enrollment in Medicaid, as set forth, are extensive. The provisions of Section 409.907, not the challenged Rule, provide the safeguards to protect Medicaid recipients and to ensure the integrity of the Medicaid program.

51. It is illogical and irrational to suggest that health, safety, and welfare are further ensured, and fraud, waste, and abuse more curbed by the additional requirement that a home health agency only provide Medicaid services through personnel that are directly employed by or under contract with the home health agency, as evinced by the issuance of W-2s or 1099s.

52. The challenged Rule is an invalid exercise of delegated legislative authority because it exceeds and contravenes the law

implemented, and is arbitrary and capricious. Based upon the foregoing Findings of Fact and Conclusions of Law, it is

ORDERED that page 1-8 of the Florida Medicaid Home Health Services Coverage and Limitations Handbook of July 2008, adopted by reference in Florida Administrative Code Rule 54G-4.130, constitutes an invalid exercise of delegated legislative authority within the meaning of Sections 120.52(8)(b), (c), and (e), Florida Statutes.

DONE AND ORDERED this 23rd day of July, 2010, in Tallahassee, Leon County, Florida.

ELEANOR M. HUNTER
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 23rd day of July, 2010.

COPIES FURNISHED:

Andrew T. Sheeran, Esquire
L. William Porter, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Andrew S. Ittleman, Esquire
Fuerst, Humphrey, Ittleman, P.L.
1001 Brickell Bay Drive, Suite 2002
Miami, Florida 33131

Scott Boyd, Executive Director/General Counsel
Joint Administrative Procedures Committee
120 Holland Building
Tallahassee, Florida 32399-1300

Justin Senior, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Thomas W. Arnold, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

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